NEW PATIENT INFORMATION (Non Medicare)

Name (Legal) ____ Prefer to be called: ________________________

Date of Birth: ________________ Sex: Male Female

Address: ____ City, State, Zip: ______________________________

Preferred Phone: _________________ (circle) Cell Home Work

Alternate Phone: _________________ (circle) Cell Home Work

Do we have your permission to leave a message on the preferred phone number above: YES NO

Email Address:____ (Required if you want access to patient portal)

Employment Status: Employed Retired Student Unemployed

Employer: ____

Primary Care Physician: ____________________________ Referring Physician: __________________________

Do we have permission to discuss your medical condition with anyone but yourself: YES NO

If yes, Whom: ____ Relationship:_______________________

Emergency Contact Name: ____ Relationship: _______________________

Emergency Contact Phone: ____________________________

Primary Language: English Spanish Other: ___________________________

Ethnicity: Are you Hispanic/Latino YES NO

Race: White Asian American Indian/Native Alaskan Native Hawaiian/Pacific Islander Other: ______________

RESPONSIBLE PARTY – IF DIFFERENT FROM PATIENT

Name _______________________________________ Relationship to Patient: ___________________________

Address: ____________________________________ City, State, Zip: ___________________________________

Phone: ______________________________ Cell Home Is it OK to leave a message? YES NO

Employer: ____ Phone: ____________________________________

INSURANCE INFORMATION

Name of Insured: ____ DOB: ________________________

Insured's Employer: ____

Sex: Male Female Relationship to Patient: Self Spouse Parent

Please turn over and complete page 2.

Financial Policy and Release of Medical Information

1. The adult/guardian who brings a child in is responsible for all out of pocket expenses, including copayments, deductibles, and non-covered services. We will not forward bills to another party regardless of court ruling or divorce decrees.
2. I authorize the release of medical information to my primary care physician, referring physician, and to consultants if needed. In addition, I authorize the release of my medical information as necessary to process insurance claims, prescriptions and for payment and collection purposes.
3. I authorize payment of medical benefits/payments to Rudolf Strnot Jr MD.
4. I understand I am responsible for any copayments, deductibles, and any other charges deemed to be my responsibility by my insurance company.
5. I understand if I do not have health insurance, payment is due at the time of service unless other arrangements have been made.
6. I understand there will be a $30.00 charge for any appointment that is missed or cancelled with less than 24 hours' notice. This will not be submitted to my insurance and must be paid prior to scheduling another appointment.

By signing below, you acknowledge your understanding and acceptance of the Information listed above.

Signature of Responsible Party: ____

Date: ________________________ Relationship to Patient: Self Other: ______________________

NOTICE OF PRIVACY PRACTICES - HIPAA Notice

A printed copy of Dr. Strnot's Notice of Privacy Practices is available upon request.
Do you want a copy for your records: YES NO

HISTORY AND INTAKE FORM

NAME:____ DATE OF BIRTH:________________________

PHARMACY (INCLUDE LOCATION):____

PAST MEDICAL HISTORY (circle all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Cancer: ____
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
GERD (Acid reflux)
Hearing loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Thyroid Problems
Pacemaker
Radiation Treatment
Seizures
Stroke
Valve Replacement
Other: ________________________________
NONE (Please circle if none of the above applies)

PAST SURGERIES (Please list and give approximate date)

____ ____
____ ____
____ ____
____ ____

SKIN DISEASE HISTORY (circle all that apply)

Acne
Actinic Keratoses – Pre Skin Cancers
Asthma
Basal cell skin cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Other____

Do you wear Sunscreen? YES NO If yes, what SPF? ____________
Do you tan in a tanning bed? YES NO
Do you have a family history of Melanoma? YES NO
If yes, which relative(s)?____
Any other family history ____

OVER

Please circle any conditions/problems you currently are experiencing:

NAME: ____

DATE: ____

Problems with Bleeding

Problems with Healing

Problems with Scarring (Hypertrophic or Keloid)

Rash

Immunosuppression

Hay Fever

Chest Pain

Fever or Chills

Night Sweats

Unintentional Weight Loss

Thyroid Problems (Hyper)

Thyroid Problems (Hypo)

Sore Throat

Blurry Vision

Bloody Urine

Abdominal Pain

Diabetes

Joint Aches

Muscle Weakness

Neck Stiffness

Headaches

Seizures

Cough

Shortness of Breath

Wheezing

Allergy to Latex, Band-Aids or Adhesive

Allergy to Lidocaine

Allergy to Topical Antibiotics Ointments

Allergy to Vicryl Suture

Artificial Heart Valve

Artificial Joints Within Past 2 years

Blood Thinners

Pacemaker or Internal Defibrillator

MRSA

Premedication Prior to Procedures

Rapid Heartbeat with Epinephrine

Oral or Implanted Birth Control

Pregnancy or Planning a Pregnancy

Breast Feeding

None

MEDICATIONS – If you brought a list, we will take a copy of it, otherwise please list below and include the dosage.

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

ALLERGIES TO MEDICATIONS – INCLUDE REACTION

____

____

____

____

____

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____

____

Cigarette Smoking (Please circle):
Never smoked
Quit: former smoker
Smokes less than one daily
Smokes daily