North Canyon MEDICAL CENTER

North Canyon Family Medicine Clinic

NEW PATIENT INTAKE FORM

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Name_____
Last First Middle
Male _____ Female _____ SSN(Required)_____-_____-_____ Date of Birth _____/_____/_____

Physical Address _____**City**_____ **State**_____ **Zip**_____

Mailing Address (if different) _____**City**_____ **State**____ **Zip**_____

Home Phone _____ **Cell Phone**_____

Email address _____ **Patient Portal: Yes____ No____**
We will not use your email for solicitation. ***Are you interested in our Patient Portal? If so, please mark above, it is utilized for your health care needs. Thank you-***

Marital Status: Married ___ Single___ Divorced___ Separated ___ Widowed/remarried___ Significant other___

Patients or Parents Employer _____ **Work Phone** _____

If minor child; list name of parent/head of household: _____

Parent/guarantor date of birth: _____**Phone number if different: (____)** _____
(MM/DD/YYYY)
Person to contact in case of emergency? _____ **Phone** _____

Relationship to patient: _____

INSURANCE INFORMATION:

Primary Insurance: _____
Name of Insured: _____ **Birth-date of Insured:** _____
Relationship to pt: _____ **SSN of insured:** _____
ID Number: _____**Group #:** _____
Amount of deductible: $_____ **or Co-Pay:** _____

Secondary Insurance: _____
Name of Insured: _____ **Birth-date of Insured:** _____
Relationship to pt: _____ **SSN of insured:** _____
ID Number: _____**Group #:** _____
Amount of deductible: $_____ **or Co-Pay:** _____

267 N. Canyon Drive Gooding, ID 83330 Phone: (208) 934-4446 Fax: (208) 934-4442

CONSENT VERIFICATION:

Consent to use of answering machine and/or voicemail messaging: I hereby consent to the use of my answering machine and/or voicemail for the purpose of relaying important information regarding my treatment or care, including, but no limited to confirmation of appointments, changes in medication, results of lab tests, special instructions for testing procedures.

I also consent to members of my family receiving this information in my absence. This consent will remain in effect until I rescind the consent in writing. I have filled out an Authorization to Release and/or Obtain Medical Information form.

_____ _____

Signature of Patient/Patient Representative **Date (MM/DD/YYYY)**

Persons who can call and receive your medical information:

Name: **Relationship** **Phone#:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Health History

This is confidential information and will be used only for the purpose of your healthcare.

Allergies to medications? ***None*** □ ***What happens?***

Medications ***None*** □

Name of Medication ***Strength/Dosage*** ***How many times a day do you take it?***

Which pharmacy do you use? _____

City: _____ State: _____

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Medical History: **Please check all that apply and describe any problems you have ever had with any of the listed topics:**

Please read carefully-	Yes	No	Comments
SKIN, HAIR, NAILS, TEETH Skin Problems? Do you wear dentures?			Additional Comments: _____ _____.
EYES, EARS, NOSE, THROAT Glasses? Hearing aids?			Additional Comments: _____ _____.
HEART PROBLEMS Have you had a heart attack? Do you have high cholesterol? High blood pressure?			Additional Comments: _____ _____ _____ _____.
LUNGS/BREATHING PROBLEMS?			
STOMACH PROBLEMS?			Additional Comments:
LIVER / PANCREAS PROBLEMS?			If so, for how long?
BOWEL PROBLEMS?			If so, for how long?
KIDNEY PROBLEMS?			If so, for how long?
ARTHRITIS/JOINT PROBLEMS?			Please describe:
HORMONE DEFICIENCIES?			
Have you ever had a stroke? Have you ever had seizures?			Additional Comments:
ANEMIA / BLEEDING PROBLEMS			Please describe:
CANCER?			Type:
DIABETES?			If so, for how long? _____ Pills or Insulin Type: **(Please circle one)**
THYROID PROBLEMS?			Please describe:
***Women*:** How many pregnancies? _____ How many deliveries? _____ Number of Miscarriages? _____ Date of your last menstrual period? _____ Have you had a hysterectomy? **Y N**			Additional Comments: _____ _____ _____ _____ _____ _____ _____.
Have you ever suffered from an addiction? Drugs and/or Alcohol?			Additional Comments: _____
Have you ever had a Venereal Disease? Have you ever suffered from depression? Have you every suffered from anxiety?			Other problems: _____ _____ _____ _____ _____.
Previous Doctors and hospitals that have provided medical care for you: Please list city/state where they are located:			Previous PCP/Clinic/Hospital: _____ _____ _____. Location: _____ _____

Other Illness/Injury: _____

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Please list previous hospitalizations and dates: _____
_____.

Preventative: Have you ever had any of these tests, and when was the testing done?

	Colonoscopy	Bone Density	Mammogram	PAP	PSA	Eye Exam	Foot Exam (If diabetic)	Rectal Exam
Date								
Normal								
Abnormal								
Due Date								
Where?								

Surgical History and Dates: _____
_____
_____.

Family History:

Father: Living □ Deceased □ How old when he passed away and why? _____

Mother: Living □ Deceased □ How old when she passed away and why? _____

Has anyone in your family had a heart attack/stroke or seizures? Yes___ No___ If So, who? _____
_____.

FAMILY MEDICAL HISTORY: **FAMILY MEMBER:** (Father/Mother/Siblings/Grandparents, etc)
(Please identify which relative has history of these conditions below)

Heart Problems (High Cholesterol/Blood Pressure)	
Lung Problems/Diseases/Disorders?	
Stomach (Gastrointestinal)/Bowel Issues?	
Liver/Pancreas Problems?	
Arthritis/Joint Issues?	
Anemia/Blood Disorders?	
Depression/Anxiety?	
Cancers?	
Thyroid Issues?	

Other:_____.

ADVANCE DIRECTIVE INFORMATION:

Do you have an Advance Directive? Yes _____ No _____

Definition: *a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.*

Do you have a Medical Power of Attorney? Yes _____ No ____ Do we have it on file? Yes ____ No ____

If so, please name: _____

Code Status: **Full Code**- All lifesaving measures □ **DNR**-Do Not Resuscitate □

I would like to talk to the doctor about this? Yes: _____ No: _____

Patient Signature: _____ **Date***:* _____

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