



New Patient or Re-establish Request Intake Form

Intake Date: ___/___/___ Form Completed By: _____

Name: _____

Date of Birth: ___/___/___ Male Female Other

How did you hear about us? _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: (____) _____ cell / home /OK to Leave Detailed Message? Yes No

Secondary Phone #: (____) _____ cell / home /OK to Leave Detailed Message? Yes No

Email Address: _____

Emergency Contact Name: _____ Relationship: _____

Phone _____

Currently Employed? Yes No Retired

Guardian Name* (if applicable) _____ Relationship: _____

Provider Requested: _____

OR No Preference Routed to: _____

Will you accept this NP? YES or NO

Date _____ Initials _____

Primary Insurance		Secondary Insurance	
Contract ID		Contract ID	
Group #		Group #	

For WFPC Staff to Review with potential patient

**Please know that our office provides and coordinates an individual health plan to meet important health goals for our patients. To do that our providers need to see patients for regular preventive appointments. Multiple years of inactivity may cause a patient's status to become inactive.*

Current and/or Previous Treatment Provider Information

Are you currently seeing another physician and/or specialist(s)? *Yes No

*If yes, which **PCP** are you seeing? _____ Location: _____

What was the date of your last Physical? ___/___/___

*If yes, which **Specialist** are you seeing? _____ Location: _____

Have you ever been discharged from another medical practice? *Yes No

*If yes, what is the name of the practice and why were you discharged?



New Patient or Re-establish Request Intake Form Required Basic Health and Prescription Information

WFPC Staff>>>>Review this explanation of health & Rx intake with potential patients

**To comply with new state regulations - part of our new patient screening process we must ask potential new patients questions about medications and health conditions to ensure we are able to provide you with the healthcare you are expecting and may require.*

**Please be aware - there could be situations when it will be determined our practice will not be able to continue certain controlled medications or courses of treatment you may be or have been receiving elsewhere.*

**The next several questions are important and are required in order to review your request to become a new patient at West Front Primary Care, LLC with our providers. If it is determined later that medications are not disclosed during the intake process it may result in discharge from the practice. Thank you for being candid.*

Are you currently taking any controlled substances? *Yes No
(i.e. Ultram, Norco, Percocet, Vicodin, Ritalin, Adderall, Vyvance or Benzodiazepines, such as Xanax, Klonopin, Ativan, Valium, etc)

*If yes, which controlled substance(s): _____

Have you been treated for or ever been diagnosed with chronic pain using regularly scheduled controlled substances? *(i.e. Ultram, Norco, Percocet, Vicodin, etc)* Yes No

What medications are you currently taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What conditions are you currently being treated for or have been diagnosed with?

_____	_____
_____	_____
_____	_____
_____	_____

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Pediatric Medical History Questionnaire

Appointment Date/Time _____

Patient's Name _____ Birth Date _____ Sex _____

Previous Physician _____ Pharmacy _____

Are you taking any medications, pills, or supplements? Yes No (Please list) _____

Are you allergic to any medication or latex? Yes No (Please list) _____

Please indicate if you have had any of the following

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Concussion | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Any other (Please list) |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Otitis media, recurrent | _____ |
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes (type) _____ | <input type="checkbox"/> Prematurity | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pyelonephritis | _____ |
| <input type="checkbox"/> Birth trauma | <input type="checkbox"/> Fracture | <input type="checkbox"/> Seizure disorder | _____ |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> GERD | <input type="checkbox"/> Urinary tract infection | _____ |
| <input type="checkbox"/> Bronchitis/bronchiolitis | <input type="checkbox"/> Headache/Migraine headache | <input type="checkbox"/> Vesicoureteral reflux | _____ |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Glaucoma/eye disorder | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headache/Migraines | <input type="checkbox"/> Thyroid Disease | _____ |

Have you had any surgeries? Yes No (please list-include year, physician and what was done)

Family History (Please list any conditions that run in your biological family-even if they are deceased or alive and well)

	Father/Mother/Child Grandfather/Grandmother Sister/Brother		Father/Mother/Child Grandfather/Grandmother Sister/Brother
	Father/Mother/Child Grandfather/Grandmother Sister/Brother		Father/Mother/Child Grandfather/Grandmother Sister/Brother



New Patient Adult Medical History Questionnaire

Appointment Date/Time _____

Provider _____

Patient's Name _____ Birth Date _____ Sex _____

Previous Physician _____ Pharmacy / Location _____

Please List any medications or supplements you are taking (list below/add separate sheet if needed)

Rx Name _____ Dose _____ Frequency _____

Rx Name _____ Dose _____ Frequency _____

Rx Name _____ Dose _____ Frequency _____

Rx Name _____ Dose _____ Frequency _____

Rx Name _____ Dose _____ Frequency _____

Rx Name _____ Dose _____ Frequency _____

Rx Name _____ Dose _____ Frequency _____

Are you allergic to any medication or latex? Yes No (Please list and include reaction)

Please indicate if you have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Any other (Please list) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis/Liver Disease | _____ |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes (type) _____ | <input type="checkbox"/> Mitral Valve Prolapse | _____ |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> GERD | <input type="checkbox"/> Respiratory Disease | _____ |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Glaucoma/eye disorder | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headache/Migraines | <input type="checkbox"/> Thyroid Disease | _____ |

What was the date of your last

Colonoscopy _____ Mammogram _____ Bone Density _____ PSA Exam _____

Have you had any surgeries? Yes No (if yes, please list the date, physician and surgery type)

Family History (Please list any **conditions** that run in your biological family-even if they are deceased or alive and well)

Mother _____

Father _____

Brother _____

Sister _____

M. Grandmother _____

M. Grandfather _____

P. Grandmother _____

P. Grandfather _____