Patient Information

Name____________________________________ SSN#______________________ Date_______________

Address______________________________ City__________________ State______ Zip______________

Home#______________________ Cell#_____________________ Work#__________________________

Birth date ___/___/____ Sex: ( ) male ( ) female Marital Status_______________________

Referred By_____________________________ Primary Physician_________________________

Employer______________________________ Occupation___________________________

Emergency Contact____________________ Relationship________________ Phone_________________

Primary Insurance___________________________ Secondary Insurance ___________________________

Email Address ___________________________ Preferred pharmacy_________________________________

Please list the name & relationship of any family members who have been seen by Dr.Roberts

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I grant Dr. Roberts and staff to contact the following individuals regarding my medical care.

Name ______________________________ Date of Birth ________________ Relationship________________

Name _______________________________Date of Birth________________Relationship________________

Please sign if we can leave a detailed message regarding treatment, results, or any healthcare related operations ____

Policy holder of insurance if different from above

Policy holder name____ Relationship_________________________

Address___________________________ City/State/Zip_________________________ Phone#___________

SSN#______________________ Birthdate_________________ Employer____________________________

*Payments of co-pays & private pay fees are due at time of service. I authorize payment directly to that physician of the surgical and/or medical benefits. I also understand I am responsible for any portion of the bill not covered by my insurance. I authorize release of information for insurance claim purposes; Photostat of the above is as valid as the original. I understand all of the above and herby stated that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorization.

HIPAA I acknowledge the opportunity to review or request the Notice of Privacy Practices.

Signed____ **Date**__________________________

Account Number ______________ Self Pay _______

We want to make sure that all our patients get the best care possible. We would like you to tell us your racial and ethnic background so that we can periodically review our patient data and make sure that everyone is receiving the highest quality of care.

1. Do you consider yourself Hispanic/Latino?

□ Yes
□ No
□ Declined

2. Which category best describes your race? (Circle any you feel apply)

□ White
□ American Indian/Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian/Other Pacific Islander
□ Other
□ Declined

ETHNICITY:

• Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

• Non-Hispanic or Latino: Patient is not of Hispanic or Latino ethnicity.

RACE:

• American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

• Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand,
and Vietnam.

• Black or African American: A person having origins in any of the black racial groups of Africa.

• Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam,
Samoa, or other Pacific Islands.

• White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

History and Intake Form

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Breast Cancer
Colon Cancer
COPD
Hypercholesterolemia
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Bone Marrow Transplantation
Hearing Loss
Hypertension
HIV/AIDS
Valve Replacement
Hyperthyroidism
Hypothyroidism
Leukemia
Lymphoma
Pacemaker
Prostate Cancer
Radiation
Seizures
Stroke

Other ____

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Knee Joint Replacement (Right, Left, Bilateral)
Hip Joint Replacement (Right, Left, Bilateral)
Hysterectomy: Uterine Cancer
Hysterectomy: Fibroids
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)

Other____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
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
None

Other____

Do you wear Sunscreen? Yes No

If yes, what SPF? ____________

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)?

____

Medications: (Please list all current medications)

____
____
____

Allergies: (Please list all allergies)

____
____

Social History: (Please circle all that apply)

Currently smokes Drug Use

Smoked in the past Never smoked

Dr. Roberts participates in E-Scripts. Below we need the following information

Pharmacy Name: ___________________________________

Phone number_________________

Pharmacy Address: ____________________________________

Fax number________________

Review of Systems: Are you currently experiencing any of the following?

(please check yes or no for the following)

Symptom	Yes	No
rash		
changing mole		
joint aches/ pain/ swelling		
muscle weakness		
hay fever/ seasonal allergies		
fever/ chills		
headache		
night sweats		
cough		
shortness of breath		
wheezing		
anxiety		
blurry vision		

Other Symptoms:

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