I N T U I T I V E M.E D I C A L G R O U P

TEL#: 908-219-8800 FAX#: 908-219-8900

NEW PATIENT APPOINTMENT

First Name	MI	Last

Address	Apt/Unit #	City:	State	Zip code

DOB	SSN	Gender ☐ Male ☐ Female	Preferred Language

Phone (H)	(C)	PREFERRED METHOD OF CONTACT: ☐ Phone (Voice) ☐ Text ☐ Email

Get connected to the patient portal! Have access to visit notes, receipts with ease!	Email For Patient Portal:

Employer	Employer Phone	Occupation

RACE		ETHNICITY	MARITAL STATUS
☐ White ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Hispanic	☐ Black or African American ☐ Other ☐ Alaskan Native ☐ Other Pacific Islander ☐ Declined	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Declined

HOW DID YOU HEAR ABOUT US?	Primary Care Physician
☐ Drive By / Signs ☐ Facebook ☐ Google / Online ☐ LA Fitness ☐ Physicians / Facility Referral ☐ Word of Mouth ☐ Mailed Flier	

Emergency Contact	Phone	Relationship to Patient

INSURANCE INFORMATION

Primary Insurance:	Relationship to Insured ☐ Primary (Self) ☐ Dependent	*PROVIDE NAME & DOB OF PRIMARY HOLDER* Name: _____ DOB: _____
Secondary Insurance:	Relationship to Insured ☐ Primary (Self) ☐ Dependent	*PROVIDE NAME & DOB OF PRIMARY HOLDER* Name: _____ DOB: _____

FINANCIAL RESPONSIBILITY

Responsible Party Name ☐ Self	Relationship to Patient	SSN	DOB

Primary Phone	Address

PREFERRED PHARMACY

Pharmacy Name	Pharmacy Cross Streets

REASON FOR YOUR VISIT TODAY (WRITE BELOW):

WHAT SYMPTOMS ARE YOU FEELING TODAY? (PLEASE MARK BELOW) ☐ **NONE APPLY**

GENERAL

☐ Fever
☐ Weight loss
☐ Weight gain
☐ Night sweats
☐ Fatigue
☐ Chills

EYES

☐ Double vision
☐ Worsening vision
☐ Floaters in the eye
☐ Blurry vision
☐ Photopsia (flashes)
☐ Pain with movement in the eye(s)
☐ Vision loss

EARS

☐ Ear Pain
☐ Drainage
☐ Dizziness
☐ Ringing in the ears
☐ Hearing Loss

NOSE

☐ Nasal obstruction
☐ Nosebleeds
☐ Sneezing
☐ Altered sense of smell
☐ Nasal discharge
☐ Sinus pain

THROAT

☐ Hoarseness
☐ Throat pain
☐ Difficulty swallowing
☐ Recurrent sore throat

ALLERGY

☐ Itchy nose
☐ Itchy eyes

RESPIRATORY

☐ Shortness of breath
☐ Snoring
☐ Dry Cough
☐ Wet Cough
☐ Coughing up phlegm
☐ Wheezing

CARDIAC

☐ Chest pain
☐ Irregular heartbeats
☐ Blood thinners
☐ Defibrillator
☐ Pacemaker

GI

☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Blood in stool

GU

☐ Difficulty urinating
☐ Frequency/ Urgency
☐ Burning urination
☐ Blood in urine
☐ Pain urinating
☐ Lower back pain
☐ Recurrent UTI's

ENDOCRINE

☐ Heat intolerance
☐ Cold intolerance

HEMATOLOGIC

☐ Bleeds easily
☐ Bruising easily
☐ Anemia

NEUROLOGIC

☐ Headaches
☐ Migraines
☐ Seizure

MUSCULOSKELETAL

☐ Knee pain
☐ Shoulder pain
☐ Hip pain
☐ Wrist pain
☐ Ankle pain
☐ Back pain

SKIN

☐ Dry skin
☐ Itching
☐ Peeling of skin
☐ Skin discoloration
☐ Rash
☐ Non healing wounds

PSYCH

☐ Anxiety
☐ Depression

ALERTS

☐ Pregnant (weeks: ____)
☐ Breast feeding

OTHER

☐ Other: _____

Allergies

Provide type of reaction (e.g. rash) ☐ **NONE**

1) _____
2) _____
3) _____

Current Medication(s)

PROVIDE DOSE/ FREQUENCY ☐ **NONE**

1) _____
2) _____
3) _____

PATIENT HISTORY

PAST MEDICAL HISTORY ☐ NONE APPLY

☐ Cancer Type & Location: _____

CARDIOLOGY
☐ Arrhythmia
☐ Atrial Fibrillation
☐ CHF
☐ High Cholesterol
☐ High Blood Pressure
☐ MI Heart Attack
☐ Valve disease

ENDO
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Thyroid Disease
☐ Obesity

GI
☐ Barret's Esophagus
☐ Cholecystitis/gallstone
☐ Cirrhosis
☐ Irritable Bowel
☐ Hepatitis C
☐ Reflux/GERD

UROLOGY
☐ BPH (Enlarged Prostate)
☐ End-stage Renal Disease
☐ Kidney stones
☐ Recurrent UTI
☐ HPV (Papilloma virus/warts)

GYN
☐ Irregular periods
☐ Ovarian Cysts
☐ # of pregnancies _____
☐ # of live births _____
☐ Date of last menstrual period _____
☐ Immuno: HIV

LYMPH
☐ Clotting Disorder
☐ Sickel Cell

ORTHO
☐ Arthritis
☐ Degenerative Joint Disease
☐ Osteoporosis
☐ Spinal Stenosis

NEURO
☐ Alzheimer's
☐ Autism
☐ CVA/Stroke
☐ Dementia
☐ Developmental delay
☐ Parkinson's
☐ Seizure

OPHTHO
☐ Blindness
☐ Macular degeneration
☐ Cataracts
☐ Glaucoma
☐ Detached Retina

PSYCH
☐ Anxiety
☐ Bipolar
☐ Depression
☐ Schizophrenia

PULM
☐ Asthma
☐ COPD
☐ Emphysema
☐ Sleep Apnea
☐ Pulmonary Embolism

RHEUM
☐ Auto-immune disorder
☐ Lupus
☐ Rheumatoid Arthritis
☐ Scleroderma
☐ Sjogren's

VASCULAR
☐ Peripheral Artery Dz
☐ Carotid Artery Stenosis
☐ Abd Aortic Aneurysm

OTHER
☐ Other: _____
☐ Other: _____

PAST SURGERIES ☐ NONE APPLY

☐ Appendectomy
☐ Kidney Stone Removal
☐ Bariatric surg. _____
☐ Gallbladder removal
☐ Colon Resection
☐ Colostomy
☐ Hernia Repair
☐ Splenectomy
☐ Lumpectomy (BIL/L/R)
☐ Mastectomy (BIL/L/R)
☐ Valve replacement
☐ Heart: CABG
☐ Cardiac Stent
☐ Heart: Pacemaker
☐ Cervical fusion
☐ Tumor Removal
☐ Bilateral Tubal Ligation
☐ Cesarean Section
☐ Cataracts
☐ Glaucoma
☐ Lung Removal
☐ Basal Cell Carcinoma
☐ Melanoma
☐ MOHS
☐ Squamous Cell CA
☐ Kidney Transplant
☐ Kidney Removal
☐ Carotid endarterectomy
☐ Other: _____
☐ Other: _____
☐ Other: _____

SOCIAL HISTORY ☐ NONE APPLY

Smoking Status: (please choose ONE of the following)

☐ Unknown if ever smoked
☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
☐ Never smoked
☐ Cigar smoke

What date did you quit smoking? _____
Number of packs a day? _____
Total years smoking? _____

Drug use? Specify below: _____

Alcohol (circle) YES/NO _____ # drinks in a week

Caffeine _____ # drinks per day

Exercise _____ # times per week

FAMILY HISTORY ☐ NONE APPLY

Do you have any FIRST DEGREE relatives with the following;

☐ Diabetes, who? _____
☐ High Blood Pressure, who? _____
☐ Bleeding disorder, who? _____
☐ Cancer, who/what kind? _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

TODAY'S DATE: _____

CDC FACILITIES COVID-19 SCREENING

Accessible version available at *https://www.cdc.gov/screening/*

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES**	**NO**
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
Are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**

Did you answer **NO** to **ALL QUESTIONS**?	Access to CDC facilities **APPROVED**. Please show this to security at the facility entrance. Thank you for helping us protect you and others during this time.
Did you answer **YES** to **ANY QUESTION**?	Access to CDC facilities **NOT APPROVED**. Please see Page 2 for further instructions. Thank you for helping us protect you and others during this time.

cdc.gov/screening

cdc.gov/screening/further-instructions.html

REV20201214

THE SCREENING YOU COMPLETED INDICATES THAT YOU MAY BE AT INCREASED RISK FOR COVID-19

IF YOU ARE NOT FEELING WELL, WE HOPE THAT YOU FEEL BETTER SOON!

Here are instructions for what to do next

1

If you are not already at home, please avoid contact with others and go straight home immediately.

2

Call your primary care provider* for further instructions, including information about COVID-19 testing.

3

Contact your supervisor (if you are an employee) or your contracting company (if you are a contractor) to discuss options for telework and/or leave.

Before going to a healthcare facility, please call and let them know that you may have an increased risk for COVID-19. In case of a life-threatening medical emergency, dial 911 immediately!

RETURNING TO THE WORKPLACE

If you have had symptoms consistent with COVID-19 or have tested positive for COVID-19, DO NOT physically return to work until you get a medical evaluation and are approved to return to a work setting by your primary care provider*. Please call your supervisor to discuss when to return to work. Read more about when it is safe to be around others at *https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/end-home-isolation.html.*

If you have a chronic medical condition that causes COVID-19-like symptoms and you need to access a CDC facility within the next few days, please call CDC's Occupational Health Clinic at 404-639-3385 to determine whether you can safely be granted access to a CDC facility.

If you have been in close contact with someone with COVID-19 you should stay home and self-quarantine for 14 days before returning to work. Read more about when you should be in isolation or quarantine at *https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html.*

If you are currently isolating or quarantining because of concerns about COVID-19 OR you have a COVID-19 test pending, please contact your primary care provider* for guidance on when you can return to work.

- If you have an urgent need to come to campus while waiting for a test result, call CDC's Occupational Health Clinic at 404-639-3385.
- If you have an urgent need to end your quarantine period early, please ask your CIO Management Officer to send an email request to eocevent106@cdc.gov and eocoht@cdc.gov.

If you have additional questions about when you can return to work, please email OSSAM@cdc.gov. For information about COVID-19 and basic instructions to prevent the spread of disease, visit CDC's COVID-19 website at *https://www.cdc.gov/covid19.*

*If you are assigned to the COVID-19, Ebola, or Polio responses, or work in a lab, call CDC's Occupational Health Clinic at 404-639-3385 instead of your primary care provider for next steps. DO NOT physically go to a CDC Occupational Health Clinic location.