STATE EMPLOYEES' INSURANCE BOARD HEALTHCARE CENTER
New Patient Intake Form

Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:**
Primary Insurance Contract Number:	**Primary Insurance Group Number:**		
Secondary Insurance Contract Number:	**Secondary Insurance Group Number:**		
Address (Street, City, State, Zip):	**Contact Phone Number:** **Preferred Contact** ☐ **CELL:** ☐ **WORK:** ☐ **HOME:**		
Email Address:	**Pharmacy:**	**Primary Physician:**	
Specialist Physician Name And Specialty:	**Specialist Physician Name And Specialty:**		
Emergency Contact:	**Phone Number:** **Relation:**		

Please list anyone that you give permission for us to discuss your personal health information with:

_____ _____
Name **Relationship to Patient**

_____ _____
Name **Relationship to Patient**

Past Medical History: *Please put a check (✓) next to all items that apply to you:*

☐ Allergic Rhinitis (Hayfever)	☐ Gastroparesis	☐ Prostate Enlargement (BPH)
☐ Anemia	☐ Glaucoma	☐ Psoriasis
☐ Anxiety / Nerves / Nervous Breakdown	☐ Gout	☐ Psoriatic Arthritis
☐ Asthma	☐ Headaches (Type:_____)	☐ Sexual dysfunction
☐ Arthritis (Type:_____)	☐ Heart attack (MI)	☐ Stroke
☐ Bladder / Kidney infections	☐ Heart disease (CAD)	☐ Sleep Apnea
☐ Cancer (Type:_____)	☐ Heart Failure (CHF)	☐ Thyroid disorder
☐ Cataracts	☐ Heart valve replacement	☐ Ulcer (PUD)
☐ Chest Pain (angina)	☐ Heartburn	☐ Urinary frequency
☐ Chronic Obstructive Lung Disease (COPD)	☐ High blood Pressure (HTN)	☐ Urinary hesitancy
☐ Chronic Pain (Type:_____)	☐ High cholesterol	
☐ Constipation	☐ High triglycerides	Other: _____
☐ Depression	☐ Incontinence	
☐ Diabetes / High Blood Sugar	☐ Insomnia (Difficulty Sleeping)	Other: _____
☐ Diarrhea	☐ Irritable Bowel (IBS)	
☐ Dizziness	☐ Menopause	Other: _____
☐ Eczema	☐ Osteoporosis	
☐ Foot Infections / Leg Sores	☐ Pneumonia	

Medication Allergies: _____

_____

Type of Reaction: _____

_____

Other Allergies: _____

_____

Additional Information Concerning Your Health History:_____

_____

_____

Past Surgical History / Hospitalizations:

Have you ever needed to go to the emergency room for care or been admitted to the hospital? Have you ever had outpatient or inpatient surgery? If so, how old were you when this happened? What was the reason for this care?

Year at Time of Care	Reason for ED Visit of Hospitalization – OR- Type of Surgery

Family History (check all that apply):

	MOM	DAD	SIBLING
☐ Diabetes	____	____	____
☐ High Blood Pressure	____	____	____
☐ High Cholesterol	____	____	____
☐ Heart Disease	____	____	____
☐ Cancer	____	____	____

Social History:

- **Tobacco:** Do you currently use any type of tobacco (cigars, cigarettes, chewing tobacco, snuff, etc.)? _____
- Have you ever used any tobacco products? _____
- If yes, what type of tobacco?_____
  At what age did you start? _____
  How long have you or did you use these products? _____
  How much did you or do you use per day on average?_____

- **Alcohol:** Do you consume alcoholic beverages?_____
- If yes, what type of alcohol do you drink?_____
- How often do you drink?_____
- How much do you typically drink each time?_____
  Do you have a history of alcohol abuse?_____

- **Drugs:** Do you use recreational drugs (marijuana, cocaine, etc.)? _____
- If so, what type?_____

- **Caffeine:** Do you ingest caffeine (colas, tea, coffee, chocolate, etc.)?_____
  How many servings of caffeinated foods or beverages do you ingest every day on average? _____

- **Diet:** Do you follow any special or restrictive diets (low-salt, low-fat, low-carb, diabetic, high protein, etc.)?_____

- **Exercise:** Do exercise regularly?_____
- If so, describe your exercise program (types of activities, frequency, length, etc.)
  _____
  _____

Do you take any prescription or over the counter medications? If so, please provide the following information:

Medication Name	Dose (milligrams, units, etc.)	When do you take it? (time of day)	When did you start taking this medication?	What is this medication for?

To help us verify your immunization record, please respond to the following:

VACCINATIONS	YES	NO
I am 50 years old or older and have had a shingles vaccination		
I have received a Tetanus/diphtheria (TD or TDaP) vaccination in the past 10 years		
I am 65 years old or older and have received a pneumonia vaccination		
I am less than 65 years old and have lung (including COPD or asthma), heart (not including high blood pressure), or liver disease; diabetes; smoke cigarettes; or have a history of alcoholism and have had a pneumonia vaccine		
I am between the ages of 12 and 26, and have received an HPV vaccine series (Gardasil® or Cervarix®)		
I am at high risk for contracting meningitis (eg. college student living in dormitories, U.S. military recruit, traveling to parts of the world where meningitis is common, exposure to meningitis during an outbreak, or working in a laboratory with routine exposure to meningococcal bacteria) and have received a meningitis vaccination.		
I receive a flu vaccination every year		

If you are interested in receiving any of our available immunizations, please speak to someone at the front desk.

If you have any questions regarding any of our available immunizations, please consult with a member of our clinical team.

AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR SERVICE. I hereby consent to the services provided by the SEIB Wellness Center. I understand that these services may include limited physical assessment, lab testing and non-invasive testing along with cognitive services.
_____ **(**initial)

PRIVACY POLICY. I acknowledge having received the "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke my consent for release of my health care information in writing, except to the extent the SEIB Wellness Center has already made disclosures with my prior consent. _____ (initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.
I authorize use and disclosure of my personal health information for the purposes of diagnosis or treatment, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the SEIB Wellness Center. I authorize the release of any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the SEIB Wellness Center may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. _____ **(**initial)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT
I authorize payment to be made directly to the SEIB Wellness Center for insurance benefits payable to me. I understand that I am financially responsible for any covered or non-covered services, as defined by my insurer.
_____ (initial)

_____	_____	_____
Patient or Authorized Person Signature	Relationship	Date

CONTACT INFORMATION FORM

Patient Request for
Confidential Communication of Protected Health Information

I,_____ (patient name), do hereby request that my pharmacist provider communicate with me in a confidential manner by using the following methods of communication and contact information when wishing to reach me.

□ If contacting me in writing:
Street Address/P.O. Box:
_____
City, State and Zip Code:
_____

□ If contacting me by telephone:
- Yes / No Talk to me only
- Yes / No May leave message with person answering phone
- Yes / No May leave message on answering machine

Telephone Number: Work / Home
_____

□ If contacting me by telephone, and I am not available please call:
Telephone Number: Work / Home
_____

□ If contacting me electronically:
E-mail address:
_____

Please indicate which contact method you prefer

Understanding and Acknowledgement

1. I acknowledge that by requesting confidential communications I may prevent the use and disclosure of my PHI to family members, friends, caregivers, and others that might be for my benefit.
2. I understand that I am responsible if the contact information provided above is incorrect, or if it is later changed and I fail to report the change.

_____ _____
Signature of Person Submitting Request Date