BAY AREA MOBILE CLINIC

Patient Intake Form

Patient Name: (Last)_____(First)_____(MI)_____
Patient Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____Cell Phone: _____
Birthdate: _____Age: _____Sex: M F
Country of Birth: _____ Country of Parents' Birth: _____
Email: _____

Past History: (Please check if you have had any of the following):

☐ Allergies, Type: _____ ☐ Birth defects or abnormalities
☐ Exposed to tuberculosis ☐ Measles ☐ Scarlatina ☐ Influenza
☐ Mumps ☐ Diphtheria ☐ Rheumatic
☐ Fever German Measles (3 day) ☐ Polio ☐ Whooping Cough
☐ Frequent Colds ☐ Chickenpox ☐ Tonsillitis ☐ Scarlet Fever
☐ Pneumonia ☐ Diabetes: Type_____
☐ Cancer, Type:_____ ☐ Other Diseases _____
☐ Operations:(dates) _____
Current Medications (vitamins, birth control pills): _____
Any mood altering or depression medication:_____

CURRENT MEDICATIONS	
Drug allergies: ❑ No ❑ Yes To what? Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements: **Name of drug**	**Dose (include strength & number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

Family History:

Father: Health _____ Age _____ Deceased _____ at age _____ Cause _____
Mother: Health _____ Age _____ Deceased _____ at age _____ Cause _____
# of siblings:_____ # living_____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)

☐ High blood pressure ☐ Allergy ☐ Heart trouble ☐ Anemia
☐ Migraine ☐ Bleeding (abnormal) ☐ Dropsy ☐ Epilepsy
☐ Strokes ☐ Cancer ☐ Diabetes ☐ Nervous breakdown

☐ Kidney disease ☐ Syphilis or (bad blood) ☐ Suicide ☐ Obesity
☐ Arthritis ☐ Rheumatic ☐ Fever
☐ Other _____

Examinations:
Date of last physical examination _____ Reason:_____
Hospitalizations _____ Dates _____ Reason:_____
X-Rays: Chest _____Stomach _____ Gallbladder _____ Kidney _____Colon _____
Other _____Date of last laboratory tests:_____
\Electrocardiogram (heart tracing) _____ Date of last pap (cancer smear): _____

Do you now have or have had any of the following?

☐ Itching	☐ Eczema	☐ Hives	☐ Joint pains	☐ Muscle aches
☐ Arthritis	☐ Limitation of motion	☐ Backache	☐ Leg pains	☐ Heel Pains
☐ Pain or stiffness (neck)		☐ Goiter	☐ Swelling, enlarged glands	
☐ Asthma	☐ Lung disease	☐ Raise sputum	☐ Emphysema Bronchitis	
☐ Heart trouble		☐ High blood pressure	☐ Shortness of breath	☐ Palpitation or fluttering
☐ Chest pain	☐ Lips or nails turn blue		☐ Tire easily	☐ Swelling of ankles
☐ Indigestion	☐ Nausea or vomiting	☐ Abdominal pain	☐ Gas or bloating	☐ Diarrhea
☐ Hard bowel movements		No. of bowel movements - daily _____		☐ Colitis
☐ Jaundice	☐ Hemorrhoids (piles)	☐ Bleeding or black stools		☐ Hernia
☐ Urinary System		☐ Kidney disease	☐ Bladder disease	☐ Kidney stones
☐ Painful urination		☐ Pus or blood in urine	☐ Albumen or sugar in urine	
☐ Dribbling of urine		☐ Varicose veins	☐ Nervousness or anxiety	
☐ Trouble sleeping		☐ Headaches	☐ Bored or depressed	☐ Nervous breakdown
☐ Fainting		☐ Convulsions	☐ Numbness	☐ Loss of consciousness
☐ Neuritis or Neuralgia		☐ Paralysis		

Menstrual History:
Menstruation began at age:_____28 day cycle? _____ If no, how many days? _____
Duration of bleeding:_____Pain with periods?_____
Amount of flow : Light _____ Med. _____Heavy _____
Date of 1st day of last: _____menstrual period:_____
Bleeding between periods:_____Bleeding after intercourse:_____
Irritation or discharge:_____Itching or burning _____

Are you on birth control? (method): _____

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Bay Area Mobile Clinic, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Bay Area Mobile Clinic. I understand that diagnosis or treatment of me by Bay Area Mobile Clinic may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Bay Area Mobile Clinic *Notice of Privacy Practices* prior to signing this document. The Bay Area Mobile Clinic *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy*

Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bay Area Mobile Clinic. This *Notice of Privacy Practices* also describes my rights and the duties of Bay Area Mobile Clinic with respect to my protected health information. Bay Area Mobile Clinic reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*.

Lifetime Authorization: By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by Bay Area Mobile Clinic.

I may obtain a revised Notice of Privacy Practices by requesting in writing from Bay Area Mobile Clinic or asking for one at the time of my next appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Bay Area Mobile Clinic (BAMC) and or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify BAMC of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined BAMC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Bay Area Mobile Clinic for all covered medical services and supplies provided to me during all courses of treatment and care provided by BAMC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with BAMC, which will authorize and allow for direct payment to BAMC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by BAMC.

_____ _____

Patient's Signature Date

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating provider, I accept full liability from any consequences arising there from.

_____ _____

Patient's Signature Date