COASTAL PINES
MEDICAL GROUP

Attachment 6: **Patient Medical Intake Form-PLEASE FILL OUT COMPLETELY**

Name (Last, First, Middle Initial):

_____ Preferred Name:_____ Marital Status:_____

DOB:_____ Gender:_____ Social Security # _____

Employment Status:_____ E-mail :_____

Home Phone #:_____ Cell Phone #_____

Preferred contact method: [ ] Phone call [ ] Text [ ] Email via portal

Home Address:_____

Mailing Address (if different):_____

Emergency Contacts-**Please fill out completely** (Name, Phone, Relationship):

- _____
- _____

Primary Insurance:_____ ID #_____

Secondary Insurance:_____ ID #_____

Prescription Insurance:_____ ID #_____

Do you give CPMG Permission to access California Vaccine Registry (CAIRS) to retrieve your vaccine history? [ ] Yes [ ] No

Do you give CPMG permission to share your electronic health records with other medical providers who share our network? [ ] Yes [ ] No

Please fill out completely. Please list all current and previous medical providers. (Primary Care, Cardiology, Neurology, Dermatology, Orthopedic, Ophthalmology, Gynecology, Urology etc)

Name	Specialty	Phone Number	City, State

Please fill out completely. Please provide date (approximate if possible) location and provider of the last time you had the following preventative care measures. If not done please write in n/a. If left blank, one of our clinical staff may contact you to obtain this information. Leaving blank may result in delay of chart completion.

Procedure	Date	Location	Ordering Provider
Recent Lab Testing			
Colonoscopy			
Cologuard			
Dexa Bone Density			
Mammogram			
Pap Test (female only)			
PSA Level (male only)			

Please list any allergies to medications or other substances (food, pets, etc.) and reactions (rash, hives, anaphylaxis, etc.) _____
_____

Please check off medical conditions that you have been diagnosed with, that you take medications for, or that you have been treated for now or in the past. Listed below are some common examples, please add any not listed.

Condition	✔	Additional Comments
Anxiety/Depression/PTSD		
Blood Clots/DVT/PE		
Cancer		
CHF/Heart Failure		
COPD or Asthma		
Diabetes		
Eye Conditions		
Heart Attack/stent/bypass		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Kidney Stones		
Thyroid		
Seizure		
Stroke/Tia		
Urine Infections		

Please list all current medications including OTC, supplements, etc.

Medication	Dose	Frequency

Please list Vaccine History. If not received please write n/a.

Vaccination	Year
Covid primary & Covid boosters	
Infulenza (annual)	
PPSV23 (single shot, after PCV15)	
PCV 20 (single shot, replaces priors)	
Tdab (tetanus) (every 5-10 yrs)	
Shingrix (new Shingles0 (2 shot series)	
Zostavax (old Shingles) (once)	

Please list all past surgeries and hospitalizations, locations and approximate dates

Procedure/Hospitalization	Location	Date

SMOKING– did you ever smoke? If so, how much for how long? _____

ALCOHOL– how many drinks do you have in a typical day/week? _____

COMMUNICATIONS: Please note that emailing and texting are NOT HIPAA secure means of communication and that third-parties can intercept such communications. Coastal Pines Medical Group provides a HIPAA secure PATIENT PORTAL through which patients can communicate with their medical team safely. Please do not ever send patient-sensitive information via email or text.

By signing below you acknowledge understanding of this notification.

By signing below you also attest that the information provided is accurate and up to date to the best of your knowledge.

I acknowledge that I have completed and agree with the above information.

Signature: _____ Date:_____

Print Name of Person Signing (if other than the patient/member):

_____

Signature: _____ Date:_____