COASTAL PINES
MEDICAL GROUP

Attachment 6: **Patient Medical Intake Form**

Name (Last, First, Middle):

_____ Preferred Name: _____

DOB: _____ Sex/Gender:_____ Social Security #: _____

Home Phone #: _____ Cell Phone #_____

E-mail: _____ Preferred contact method:_____

Permission to receive automated reminders via: Text [ ] E-mail [ ]

Home Address: _____

Mailing Address (if different): _____

Emergency Contact (s) (NAME, PHONE, RELATIONSHIP):

- _____
- _____

Preferred Pharmacy: _____

Primary Insurance: _____ ID# _____

Secondary Insurance: _____ ID# _____

PREVIOUS / OTHER DOCTORS (Primary Care, Cardiologist, Neurologist, Ophthalmologist, Dermatologist, Orthopedist, etc.)

NAME	SPECIALTY	CITY, STATE
	Primary Care	

Do you give CMPG permission to access the California Vaccine Registry (CAIRS) to retrieve your vaccine history? YES [ ] NO [ ]

Do you give CMPG permission to share your electronic health records with other medical providers who share our network? YES [ ] NO [ ]

Vaccination	Year
Tdap (tetanus) (every 5-10 yrs)	
Zostavax (old Shingles) (once)	
Shingrix (new Shingles) (2 shot series)	
PCV 15 (single shot followed by PPSV23)	
PPSV23 (single shot, after PCV15)	
PCV 20 (single shot, replaces priors)	
COVID (primary)	
COVID (boosters)	
INFLUENZA (annual)	

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

_____

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

Medication:	Dose:	Frequency:

Please list all past surgeries and hospitalizations and approximate date

Procedure/Hospitalization:	Date:

Please list all 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, but please, add on.

CONDITION	Yes or No	BRIEFLY DESCRIBE OR COMMENT
HIGH BLOOD PRESSURE		
HIGH CHOLESTEROL		
HEART attack/stent/bypass		
CHF / HEART FAILURE		
COPD or ASTHMA		
KIDNEY DISEASE		
DIABETES		
CANCER		
STROKE/TIA		
THYROID		
KIDNEY STONES		
URINE INFECTIONS		
BLOOD CLOTS (DVT/PE)		
EYE ISSUES		
SEIZURES		
ANXIETY/DEPRESSION/PTSD		

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

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

Please, provide date (approximate if necessary) and location/provider of the last time you had the following preventative care measures.

Procedure:	Date AND Where done / by Whom
COLONOSCOPY/STOOL TESTING	
MAMMOGRAM	
PAP TEST (FEMALE ONLY)	
DEXA BONE DENSITY	
PSA LEVEL (MALE ONLY)	

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.

Print Patient/Member Name: _____

Signature: _____ Date:_____

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

_____

Signature: _____ Date:_____