EMMANUEL PROJECT

NEW PATIENT INTAKE FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

FIRST NAME	LAST NAME	DATE OF BIRTH
		_____/_____/_____

SEX	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS
❑ Male ❑ Female			

ADDRESS		
CITY	STATE	ZIP CODE

MARITAL STATUS	SPOUSES NAME	SPOUSE PHONE NUMBER
❑SINGLE ❑MARRIED		
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION

DO YOU HAVE INSURANCE?	PRIMARY CARD HOLDER	PRIMARY POLICY HOLDER NAME
❑YES ❑NO	❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	PRIMARY GROUP NUMBER
DO YOU HAVE SECONDARY INSURANCE?	SECONDARY CARD HOLDER	SECONDARY POLICY HOLDER NAME
❑YES ❑NO	❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	SECONDARY GROUP NUMBER

PRESCRIPTION POLICY

PHARMACY NAME	PHARMACY PHONE NUMBER

PATIENT SIGNATURE	**DATE**

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[redacted]

Allergies

❑ NONE/Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Contrast ❑ Latex ❑ Morphine ❑ Penicillin

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid Disorder		

SOCIAL HISTORY

□**Yes** □**No** - Do you drink alcohol? □ Daily □Weekly □Infrequently □ Recovering Alcoholic
□**Yes** □**No** - Do you smoke? □ Smoke (___ packs per day) □ Chew
□**Yes** □**No** - Do you drink caffeine? □ Daily □Weekly □Infrequently
□**Yes** □**No** – Are you sexually active?
□**Yes** □**No** – Do you wish to be checked for STDs?

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed
❑ Allergies
❑ Anemia
❑ Arthritis conditions
❑ Asthma
❑ Arterial fibrillation
❑ Bleeding problems
❑ BPH
❑ CAD coronary artery disease
❑ Cancer
❑ Cardiac arrest
❑ Celiac disease
❑ Chest pain
❑ Congestive heart failure
❑ Chronic fatigue syndrome
❑ Depression
❑ Diabetes
❑ Drug/alcohol abuse
❑ Erectile dysfunction
❑ Fibromyalgia
❑ Gerd
❑ Heart disease
❑ Hyperinsulinemia
❑ Hyperlipidemia
❑ Hypertension
❑ Hypogonadism male
❑ Hypothyroidism
❑ Infection problems
❑ Insomnia
❑ Irritable bowel syndrome
❑ Kidney problems
❑ Menopause
❑ Migraines/headaches
❑ Neuropathy
❑ Onychomycosis
❑ Organ injury
❑ Osteoporosis
❑ Pulmonary embolism
❑ Seizure disorders
❑ Shortness of breath
❑ Sinus conditions
❑ Stroke
❑ Syndrome X
❑ Tremors
❑ Wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR