Instructions:

- Step 1 – Print this PATIENT INTAKE FORM and fill it out
- Step 2 – Scan and email it to us or fax it to us or bring it with you to your appointment
- Step 3 – Call 719-687- 6088 Monday – Friday from 12pm to 6pm to schedule your appointment

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ALLERGIES _____

Patient Name _____ Date of Birth _____ Today's Date _____
Street Address _____
Mailing Address _____
City, State, Zip _____ Home Phone # _____
SSN_____ Pharmacy Preference _____
Email Address _____
Insurance Co_____ ID#_____ Group#_____
Policy Holder_____ SSN_____ DOB _____
Patient's Relationship to Policy Holder: Self _____Spouse _____ Child_____

EMERGENCY CONTACTS

Name _____Relationship to Patient _____ Home/Cell _____

Name _____Relationship to Patient _____ Home/Cell _____

SOCIAL HISTORY

Relationship status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Birthplace _____ Education/Degree _____

Employer_____ Occupation _____

LIFESTYLE CHOICES

Exercise Type _____ Times per week _____ Duration _____

Alcohol Drinks per week?_____ For how long?_____

Caffeine Cola Coffee Tea Drinks per day _____

Smoking If yes: Age you started?_____Age you quit?_____ How much per day? _____

MEDICATIONS, VITAMINS, SUPPLEMENTS

Circle the following non-prescription items that you use:

Acetaminophen	Ibuprofen (Advil,Motrin)	Supplements
Allergy Pills	Laxatives	Vitamins (Please list)
Antacids	Naproxen (Aleve)	Herbs (Please list)
Aspirin	Nasal Sprays	
Decongestants	Natural Hormones	

Please list your prescription and dosages of medications you take: _____

_____

PREVENTIVE SERVICES

Last Physical _____Physician_____ List the **AGE** you last had these services or tests.

Screening	**Health Maintenance**	**Immunizations**
Mammogram _____	Dentist Visit _____	Last Tetanus _____
Pap smear _____	Eye exam _____	Shingles shot _____
Colonoscopy _____		Pneumonia shot _____
Prostate check _____		HPV _____
Bone Density _____		Flu _____

Specialists you are seeing _____

MEDICAL HISTORY/SURGERIES:

Please list medical history and any surgeries you may have had, along with **AGE** at time of service:

_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Tell us about your **immediate family** members: Check here ☐ if you were ADOPTED

Family Member	**Birth Year**	**Health Status**	**If Deceased**	
			Age at Death	**Cause**
Father				
Mother				
1. Brother/Sister *(circle one)*				
2. Brother/Sister				
3. Brother/Sister				
Spouse				
1. Son/Daughter *(circle one)*				
2. Son/Daughter				
3. Son/Daughter				

Circle any of the following symptoms you've had in the **last 2 weeks.**

General
loss of appetite
weight loss
chills fevers
sweats fatigue
sleep disorder

Eyes blurred vision
double vision vision
loss or blindness
discharge redness eye
pain yellow eyes

Ear/Nose/Throat
ear drainage
earaches hearing
loss ear ringing
nose bleeds
snoring sore
throat
hoarseness

Endocrine
urinating a lot drinking
a lot poor wound
healing temperature
intolerance hot flashes

Cardiovascular chest
pain or pressure
swelling in feet calf
pain with walking
irregular heart beats
palpitations fainting
lightheadedness

Respiratory
cough
sputum short
of breath
coughing
blood
pleurisy
wheezing

Gastrointestinal
abdominal pain
difficulty or painful
swallowing
indigestion nausea
vomiting diarrhea
constipation change in
bowel habits black
tarry stool blood in
stools
jaundice

Blood/Lymph
bleeding easy
bruising swollen
lymph nodes

Genito-urinary
decreased stream
painful urination
frequency blood in
urine getting up to
urinate at night
urinary incontinence
abnormal
menstrual
periods vaginal
discharge pelvic
pain genital
lesions penile
discharge
erectile dysfunction

Musculoskeletal
joint pains
joint swelling
stiff joints
neck pain
back pain
muscle cramps
muscle weakness

Neurological
balance problems
difficulty walking
frequent falls
dizziness
headaches
memory
problems
numbness
seizures tremor
weakness

Breast lump
tenderness
nipple discharge

Skin changed
mole hair
changes itchy
skin rash
skin color change

Allergic
anaphylaxis hay
fever
hives

Psychiatric
abusive
relationship anxiety
depression mood
swings behavior
problems confusion
memory problems
excessive alcohol
consumption illegal
drug usage
hallucinations
paranoia school
difficulties
separation anxiety
sexual difficulty
sleep disturbance
suicidal thoughts

MENSTRUAL HISTORY First date of last period _____If menopausal, age at last period_____
Periods irregular? ☐ Yes ☐ No How many pregnancies _____Number of children born alive_____

Birth Control: ☐ Pills☐ Condoms ☐ IUD ☐ Surgery ☐ Other _____

ASSIGMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical and surgical benefits to Richard Y. Harris, MD for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize direct payment of medical and surgical benefits to Richard Y. Harris, MD for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Richard Y. Harris, MD to release any medical or incidental information that may be necessary for either medical care, or in processing applications for financial benefit.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct and authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

Patient Name_____ **Date**_____
(Please Print)

Parent/Guardian_____ **Date**_____
(Please Print)

SIGNATURE_____
HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my Treatment).**
- **Obtaining payment from third party payers (I.E, my insurance company).**
- **The day to day healthcare operation of your practice.**

I have also been informed of and given the right to review and source a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____. 20_____

Print Patient Name _____

Relationship to Patient _____

Signature _____

Information can be released to:

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____