Instructions:

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

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ALLERGIES: _____

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

EMERGENCY CONTACTS

Name _____Relationship to Patient _____ Home/Cell _____

Name _____Relationship to Patient _____ Home/Cell _____

SOCIAL HISTORY

Who lives at home with you?

_____

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

Birthplace _____ Education/Degree Level _____

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

Please list your prescription medications:

_____

_____

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				

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 _____

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

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.

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_____