New Patient Intake Form
White River Family Practice

Patient Name: ______________________ Date of Birth:______ Last Four SSN: ______
(last name, first name, middle initial) Birth Sex: ☐Male ☐Female
Mailing Address:____
(Street) (City/State/Zip)
Physical Address (if different from mailing):______________________
Home Phone:______________________ Cell Phone:______________________
Marital Status: ☐Married ☐Single ☐Divorced ☐Widow
Race: ☐White ☐African American ☐American Indian ☐Asian ☐Other
Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino
Primary Care Provider:______________________
Primary Language:______________________ E-Mail address:______________________
Employer:______________________ Occupation:______________________
Work Phone:______________________
Preferred Pharmacy:______________________
Preferred Name (what do you prefer we call you, if different than above):______________________

FIRST INSURANCE INFORMATION:
Plan Name:______________________ Policy Number:______________________
Address:______________________ Group Number:______________________
Policy Holder:______________________ Policy Holder's Date of Birth:______________________
Policy Holder's Relation to Patient:______________________ Effective Date:______________________

SECOND INSURANCE INFORMATION:
Plan Name:______________________ Policy Number:______________________
Address:______________________ Group Number:______________________
Policy Holder:______________________ Policy Holder's Date of Birth:______________________
Policy Holder's Relation to Patient:______________________ Effective Date:______________________

PARENT/GUARDIAN or PERSON RESPONSIBLE FOR BILL (Complete only if different from patient):
Name:______________________ Social Security Number:______________________
Address:______________________
Home Phone:______________________ Relation to Patient:______________________

PRIOR HEALTH CARE/ADVANCE DIRECTIVES:
Last Primary Healthcare Provider – Name & Location:______________________
Do you have a **Living Will**: ☐Yes ☐No
Do you have a **Durable Power of Attorney** for Health Care: ☐Yes ☐No
If yes, who:______________________ Relationship:______________________
Phone number:______________________

New Patient Intake Form
Primary Care

Name:

MR#:

DOB:

PAST MEDICAL HISTORY (check only if applies):

- ☐ ADD or ADHD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Benign Breast Disease
- ☐ Bipolar
- ☐ Chlamydia (sexually transmitted infection)
- ☐ Chronic Hepatitis or Liver Disease
- ☐ Chronic Kidney Disease
- ☐ Chronic Pain
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
  - ☐ Type I
  - ☐ Type II
- ☐ Diverticulitis
- ☐ DVT (blood clot in leg)
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ GERD or reflux disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Stones
- ☐ Migraine Headaches
- ☐ Osteoarthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Psoriasis
- ☐ Pulmonary Embolism (blood clot in lung)
- ☐ Recurrent Urinary Tract Infections
- ☐ Seizure Disorder
- ☐ Skin Cancer
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Street Drug Use
- ☐ Stroke
- ☐ Thyroid Disease

- ☐ Other disease not listed above: ______________________________
- ☐ Other disease not listed above: ______________________________
- ☐ Cancer – Type: ______________________________
- ☐ Cancer – Type: ______________________________
- ☐ Hospitalization – Reason/Year: ______________________________
- ☐ Hospitalization – Reason/Year: ______________________________
- ☐ Hospitalization – Reason/Year: ______________________________
- ☐ Hospitalization – Reason/Year: ______________________________
- ☐ Surgery – Type/Year: ______________________________
- ☐ Surgery – Type/Year: ______________________________
- ☐ Surgery – Type/Year: ______________________________
- ☐ Surgery – Type/Year: ______________________________

Women only: Age at first period:__________ Age at menopause:__________
# of pregnancies:_____ # of live children born:_____ # of miscarriages or abortions:______

MEDICATIONS (Including eye drops/creams/supplements/over-the-counter medications)**:**
(list all with dose and frequency) Please attach a separate sheet if you need more room: ☐ see attached

____
____
____

ALLERGIES (Including medications, foods, other environmental triggers such as Latex)**:**
(give reaction details such as hives, swelling, diarrhea, etc)

____
____
____

New Patient Intake Form
Primary Care

Name:

MR#:

DOB:

FAMILY HISTORY (relative – for example mother, father, sibling, etc.):

- ☐ Heart Attack – Relative/Age:__________
- ☐ Heart Disease – Type/Relative:__________
- ☐ High Cholesterol – Relative/Age:__________
- ☐ Diabetes – Relative:__________
- ☐ Sudden Unexplained Death – Relative/Age:__________
- ☐ Colon Cancer – Relative/Age:__________
- ☐ Breast Cancer – Relative/Age:__________
- ☐ Cancer – Type/Relative:__________
- ☐ Cancer – Type/Relative:__________
- ☐ Other Illnesses - Relative:__________
- ☐ Other Illnesses - Relative:__________
- ☐ Other Illnesses - Relative:__________
- ☐ Other Illnesses - Relative:__________

SOCIAL HISTORY:

Who do you live with? __________

Do you feel safe at home? ☐ Yes ☐ No Have you ever felt threatened in your home? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes – how much per day:______ for how long:______

Did you smoke in the past? ☐ Yes ☐ No If yes – how much:______ for how long:______

Do others at home smoke? ☐ Yes ☐ No If yes – who:__________

Do you chew tobacco? ☐ Yes ☐ No If yes – how much:______ for how long:______

Do you drink alcohol? ☐ Yes ☐ No If yes – how many drinks per week:______

Do you use marijuana? ☐ Yes ☐ No

Do you use other street drugs ☐ Yes ☐ No If yes – what:__________

Sexual partners (now or in past): ☐ Male ☐ Female ☐ Both ☐ None

PREVENTATIVE HEALTH CARE INFORMATION (approximately**):**

Last Physical Exam:	Date: ______		
Last blood test for Cholesterol:	☐ Normal	☐ Abnormal	Date: ______
Last blood test for Sugar/Diabetes:	☐ Normal	☐ Abnormal	Date: ______
Last Pap smear:	☐ Normal	☐ Abnormal	Date: ______
Last Mammogram:	☐ Normal	☐ Abnormal	Date: ______
Last Colon Cancer screen:	☐ Normal	☐ Abnormal	Date: ______
Have you had a Pneumonia shot?	☐ Yes	☐ No	Date: ______
Have you had a Shingles shot?	☐ Yes	☐ No	Date: ______
Do you recall last Tetanus?	☐ Yes	☐ No	Date: ______

White River Family Practice, PC 331
Olcott Drive, Suite U3 White River
Jct., VT 05001
802-295-6132
802-295-1358 (Fax)
www.whiteriverfamilypractice.com

Name:________________________________ DOB:______________ MRN:______________

I authorize ____ to disclose my protected health information for the following purpose of **Continuity of Care** ___, transferring care _______.

I understand this information may include treatment for drug/alcohol abuse, mental illness, HIV status, or genetic testing records. I specifically authorize the release of this information (if applicable):

☐ Yes ☐ No Initials:______

Name of person(s) or entity to receive information:
White River Family Practice
331 Olcott Dr. Ste U3
White River Jct., VT 05001

If medical records are more than 25 pages please mail them to our office.

INFORMATION TO BE DISCLOSED:

Information Needed:

☐ Problem List
☐ Immunization
☐ Medication List
☐ Last year of progress notes
☐ Last physical
☐ Last 3 years of consults
All ADHD Evaluations
☐ Last year of labs/images
☐ Last pap
☐ Most recent mammogram
Most recent colonoscopy

I understand that:

- I may refuse to sign this authorization and my healthcare and payment of my healthcare will not be effected based upon refusal to sign the authorization.
- I may revoke this authorization at any time by delivering to the health care provider/institution, authorized above, in a written note. I understand that the revocation will not apply to records that have been disclosed prior to receipt of the written revocation.
- If I authorize disclosure of my protected health information, and the recipient is not a covered entity, the recipient may further disclose this information and federal law will no longer protect it.
- I have the right to inspect of copy the information that I am consenting to release within the established policies of the provider or institution that I authorize to release my records.

This authorization will expire one year from the date this document is signed unless I otherwise specify an alternative date or event described here:____

____ ___________________ _____________
Signature of Patient/Personal Representative Phone Number Date

____ ______________________________________
Printed Name of Personal Representative Legal Authority of Personal Representative

We will provide you a copy of this authorization at your request.