NEW PATIENT INTAKE - ALLERGY

Full Name: _____ Date: _____

Sex (circle): M F Birth Gender (circle): M F

Race (ie: White, Asian, African American): _____ Hispanic or Latino: ___Yes ___No

Marital Status: ___Single ___Married ___Widowed ___Separated ___Divorced

Name of Emergency Contact: _____Phone: _____

Relationship to Patient: _____

Please list all ***known DRUG and FOOD allergies***:

Drug Name and/or Food:	Reaction:
_____	_____
_____	_____
_____	_____

List **ALL** medications & supplements you take (prescription & over the counter)

Drug Name:	Dosage:	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check **ALL medical conditions** that you may have had or currently have now:

__ADD/ADHD	__Depression	__Hepatitis	__Miscarriage
__Alcoholism	__Diabetes	__High Blood Pressure	__Multiple Sclerosis
__Allergy	__Eczema	__High Cholesterol	__Parkinson's
__Alzheimer's	__Emphysema	__High Blood Sugar	__Pneumonia
__Anemia	__Epilepsy/seizures	__HIV/AIDS	__Raynaud's
__Appendicitis	__Fibromyalgia	__Irritable Bowel	__Rheumatoid Arthritis
__Asthma	__Gall Bladder	__Kidney Stones	__Ringing in ears
__Arthritis	__Goiter	__Low Blood Pressure	__Sinus Infection
__Cancer	__Gout	__Low Blood Sugar	__Stroke
__Celiac Disease	__Heart Attack	__Lyme Disease	__Thyroid Problems
__Chronic Fatigue	__Heart Disease	__Lupus	__Ulcers
__Migraine	__Vertigo/Dizziness		

Other: _____

Please list all previous surgeries & dates:

_____

_____

Alcohol use? Yes / No Amount _____ Daily / Weekly / Socially

Tobacco use? Yes / Never / Former Smoker PPD _____ How many years? _____

AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes_____ No_____

I fully understand that my signature is consent and authorization to be examined by the Center for Wellbeing medical team.

Patient Signature _____ Date _____

Authorization to Disclose Medical Records and Health Information

Patient Name:

Date of Birth:_____ Phone:

Records Release To:

Provider/Clinic/Organization:_____CENTER FOR WELLBEING

Address:_____3201 Lafayette Road Portsmouth, NH 03801

Phone:_____603-380-9159_____Fax_____603-427-8290

I hereby authorize the release of my medical records to the provider designated above.

Please Initial

_____ Complete Medical Record

Patient Signature:_____ Date:

CENTER FOR WELLBEING®

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that if you must cancel your appointment, you provide a 24-hour notice. Appointments which are cancelled within less than 24-hour notice may be subject to pay the full balance owed at the time of cancellation. Cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that unavoidable circumstances may cause you to cancel with less than a 24-hour notice, fees may be waived upon management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no-show fees can be directed to the front desk at (603) 380-9159.

Please sign that you have read, understand, and agree to this cancellation and no-show policy.

_____

Patient Name (Please Print) Date

_____

Signature of Patient Date