COASTAL PINES
MEDICAL GROUP

Patient Intake Form

Name(Last,First,MiddleInitial):_____

DOB: _____Sex: (Circle One)Male Female SS#_____

Preferred Phone Number: _____Home/Cell (circle one)

Email: _____

Home Address:
_____

City:_____ Zip Code:_____

Employer: _____Marital Status:_____

Emergency Contact: _____Relationship:_____

Emergency Contact Phone Number: _____

Preferred Pharmacy:_____

Preferred Lab:_____Preferred Imaging Center:_____

Previous Primary Care Doctor:_____

Phone:_____ Fax:_____

Insurance Information:

Primary:_____Policy #_____Group#_____

Secondary:_____Policy#_____Group#_____

Please List all Vaccinations

Vaccinations	Date

Please list all other treating physicians (i.e. cardiologist, orthopedist, dermatologist, ophthalmologist, etc.)

Doctor's Name	Specialty

Please list all current medications including OTC, supplements, etc.

Medication:	Dose: Frequency:

Please list any allergies to medications or other substances (food, pets, etc.) and reactions (rash, hives, anaphylaxis,etc.) _____
_____

Please list all past surgeries and hospitalizations and approximate date

Procedure/Hospitalization	Date:

Have you ever had the following:	Yes	If yes, please briefly describe
Arthritis		
Breathing/Lung Problems		
Bleeding/Clotting Problems		
Blood Pressure Problems		
Blood Transfusion		
Bowel/Stomach Problems		
Cancer		
Cholesterol Problems		
Diabetes		

Eye Issues		
Gynecological issues		
Heart Disease/Disorder		
Liver Disease		
Neurological Disorder (including headaches)		
Psychiatric Disorder		
Blood Clots (PE/DVT)		
Stroke		
Seizure/Epilepsy		
Thyroid Disorder		
Urinary/Kidney Disorder		

Please indicate any major conditions/illnesses that your immediate family members have had

Relative	Condition and Description

Smoking Status:

- ☐ I am a current smoker, I smoke ___packs/day for the past ___years
- ☐ I am currently not a smoker. I have smoked in the past/day___packs for__years
- ☐ I have never smoked

Alcohol Consumption:

- ☐ Yes. How many drinks and how often? _____
- ☐ No

Ethnicity:

- Decline Response
- Hispanic or Latino
- Not Hispanic or Latino

Race:

- Decline Response
- American-Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- Caucasian
- Other

I have completed and agree with the above information:

Patient Signature:_____Date:_____

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