Choice Medical Walk-In Family Practice
Phone: 623.434.5748 Online: www.choicemedicalwalkin.com
Anthem Office - 3624 W. Anthem Way, Suite C-122, Anthem, AZ 85086
Peoria Office - 9947 W. Happy Valley Parkway, Suite 104, Peoria, AZ 85383

PATIENT INTAKE FORM

(Please Print)

Today's Date:	**Preferred Pharmacy:**

PATIENT INFORMATION

Patients Name: (Last Name) (First Name) (Middle)			
DOB:	SSN:	Gender: Male / Female	Marital Status:
Home Address:			
P.O. Box:		City:	State: Zip:
Home Phone:		Cell Phone:	Work Phone:
Race/Ethnicity:		Email:	

Advance Directive: YES [ ] "I will provide my PCP with a copy for my chart." NO [ ]

EMPLOYMENT INFORMATION *If patient is under 18yrs, please provide Primary Cardholders Employment information.

Employer Name:	Employer Phone:
Employer Address:	Job Title:

EMERGENCY CONTACT

Contact Name:	Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:

NEXT OF KIN If the same as emergency contact [ ]

Contact Name:	Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:

INSURANCE INFORMATION

(Please make sure we have an updated insurance card on file)

Primary Insurance Name:			
Policy Holder's full name:			DOB:
Patient's relationship to policy holder: [ ] Self [ ] Spouse [ ] Child [ ] Other			
Address of policy holder: If the same as above [ ]			
Street:	City:	State:	Zip:
ID#	Group#	SS#	

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PATIENT INTAKE FORM

INSURANCE INFORMATION Continued			
Secondary Insurance Name:			
Policy Holder's full name:			DOB:
Patient's relationship to policy holder: [ ] Self [ ] Spouse [ ] Child [ ] Other			
Address of policy holder: If the same as above [ ]			
Street:	City:	State:	Zip:
ID#	Group#	SS#	

ACKNOWLEDGMENT OF STATED INFORMATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be directly paid to Choice Medical Walk-In. I understand that I an financially responsible for any balance my insurance coverage does not cover. I also authorize Choice Medical or insurance company to release any information required to process my claims. I I acknowledge that I have read and understood the HIPPA form.(A copy of the HIPPA form is posted in our lobby or a copy can be provided to you upon request.)

X: _____ _____

Patient / Guardian Signature Date

If patient is under 18, person signing, Guardian, for patient is responsible for the bill…

How did you hear about our Clinic?

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PATIENT INTAKE FORM – PATIENT HISTORY

(Please Print)

Name:

CURRENT/PAST MEDICAL HISTORY	SURGERIES HISTORY	FAMILY HISTORY
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5

SOCIAL HISTORY

Exercise	[ ] Sedentary (No exercise) [ ]Mild exercise [ ] Occasional vigorous exercise [ ] Regular vigorous exercise				
Diet	Are you dieting?			[ ] Yes	[ ] No
	If yes, are you on a physician prescribed medical diet?			[ ] Yes	[ ] No
Caffeine	[ ] None	[ ] Coffee	[ ] Tea	[ ] Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			[ ] Yes	[ ] No
	[ ] Occasional 2-4 drinks monthly [ ] Regular 2-4 drinks weekly				
	Are you concerned about the amount you drink? Have you considered stopping?			[ ] Yes	[ ] No
Tobacco	Do you use tobacco?			[ ] Yes	[ ] No
	[ ] Cigarettes - pks./day	[ ] Chew - #/day	[ ] Pipe - #/day	[ ] Cigars - #/day	
	[ ] # of years	At what age did you quit?			
Drugs	Do you currently use recreational or street drugs?			[ ] Yes	[ ] No
	Have you given yourself street drugs with a needle?			[ ] Yes	[ ] No

Date of Last PAP (if applicable):		
Heavy periods, irregularity, spotting, pain, or discharge?	[ ] Yes	[ ] No
Number of pregnancies _____ Number of live births _____		
Have you had a D&C, Hysterectomy, or Cesarean?	[ ] Yes	[ ] No
Date of Last Physical Exam:		
Date of Last Clonoscopy (if applicable):		

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PATIENT INTAKE FORM – PATIENT HISTORY

ALLERGIES TO MEDICATIONS	
Name the drug	Reaction you had

LIST YOUR PRESCRIBED DRUGS-AND-OVER THE COUNTER DRUGS, SUCH AS VITAMINS		
Name the Drug/ Strength/ Frequency	Name the Drug/ Strength/ Frequency	Name the Drug/ Strength/ Frequency

Misc Comments