Greater Regional HEALTH

PHI Released ____

MRN:

Date: _____ Initials of Staff _____

New Patient Intake Form- Clinics

Patient Name: _____ Gender: M F Birth Date: _____
Address: _____City/State:_____Zip:_____County:_____

Phone Number: _____ May we leave a message? YES NO

Guardian/Power of Attorney: _____ Relationship: _____ Phone: _____

Emergency Contact:_____Relationship_____Phone: _____

DOCTOR PREFERENCE:

☐ FAMILY MEDICINE: Preferred:
☐ INTERNAL MEDICINE: Preferred:
☐ PSYCHIATRY – Info on back

CLINIC LOCATION PREFERENCE:

☐ CRESTON ☐ LENOX ☐ MT. AYR ☐ CORNING

MEDICAL INFORMATION:

Past Doctor/Clinic: _____ City/Address/Phone: _____

Reason for Changing: _____

Current Health Concerns: _____

Chronic Illnesses/Continuing Medical Conditions: _____

_____

Are you under the treatment of any specialty providers? _____ Specialty? _____

_____

Surgeries in Last 3 Year: _____

Medications: _____

_____

Current Pharmacies: _____

Are you currently Active Military? Yes No

☐ **OB** **CURRENTLY PREGNANT:** **LAST MENSTRUAL PERIOD:**

Number of Pregnancies: Number of Living Children: Prior C-sections? NO YES

Issues with past pregnancies: _____ City/Address/Phone: _____

Current OB Doctor: _____

City/Address/Phone: _____

Reason for Change: _____

PCP: _____ Appt Needed? ☐ Yes ☐ No Sent to Phone Nurse: _____ Answered Pt to VM Date/Time_____
Patient notified of Decision via: ☐ Phone ☐Voicemail By: _____ Date/Time_____

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Patient Name: _____Gender: M F Birth Date:_____

Address: _____City/State:_____Zip:_____County:_____

Phone Number:_____ May we leave a message? YES NO

Guardian/Power of Attorney: _____ Relationship_____ Phone:_____

Emergency Contact: _____ Relationship_____Phone: _____

☐ PSYCHIATRY

Current Psychiatrist: _____City/Address/Phone: _____

Past Psychiatrist/How long ago: _____ City/Address/Phone: _____

Reason for Changing: _____

_____

Current Concerns: _____

_____

Medications: _____

_____

Primary Physician: _____