1630 Military Cutoff Rd. Suite 104
Wilmington, NC 28403
910.679.8534 (Tel)
910.679.8535 (Fx)

Patient Intake Form

Name ________________________________ **Age** _____ **Birth Date** ____/____/____
Sex ______ **Address** ____
City ______________ **Zip** _________ **Phone** ______ __________________
Occupation _______________________________________ **Full Time / Part Time**
Marital Status: ___ **Married** ___**Separated** ___ **Divorced** ___**Widow** ___ **Single** ___
Other _____ **Children (ages)** ____________________________

How did you hear about us? ___________________________

Emergency Contact:
Name __________________ **Phone** _______________ **Relationship** _______________

Allergies: ____

Please list your most concerning health care problems (in order of importance to you):
1. ____
2. ____
3. ____
4. ____
5. ____

Past Surgical History:

Please list any Surgical Procedures you have had and the approximate dates:
1. _______________________________ **Date** ______________
2. _______________________________ **Date** ______________
3. _______________________________ **Date** ______________
4. _______________________________ **Date** ______________
5. _______________________________ **Date** ______________

Family History:
Please Circle any of the following diseases that tend to run in your family and list what relatives (father, grandmother, etc.)
Diabetes: ___________________ **Heart Disease:** ______________________
Stroke: ___________________ **High Blood Pressure:** ___________________
Seizures: ______________________

Past Medical History:

- ❑ ADD/ ADHD
- ❑ Allergies
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Blood Clots
- ❑ Cancer, Types:
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes, Type 1 or 2
- ❑ GERD
- ❑ Heart Disease
- ❑ Hepatitis (A, B, C)
- ❑ Hypertension
- ❑ Kidney Disease
- ❑ Lymphoma
- ❑ Osteoporosis
- ❑ Thyroid Disease
- ❑ Seizures
- ❑ STD
- ❑ Stomach/ Colon Disease
- ❑ Stroke
- ❑ Other: ______________________ _______________

Please list any medications you are currently taking, the dose, and how often you take them:

1. ____
2. ____
3. ____
4. ____
5. ____

Social History:

Please check beside any of the following you have used in the past or currently:

______ **Alcohol (beer, wine or spirits)**

______ **Recreational Drugs**

______ **Tobacco (cigarettes, cigar, etc.)**

______ **Tobacco (chewing)**

______ **Coffee**

______ **Birth Control Pills**

______ **Vitamins / Supplements**

______ **Herbal Products**

CANCELLATION POLICY:

We strive to provide excellent medical care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets aside ample time for our patients. “No-shows” and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented this policy:

1. We request you give a 24-hour notice in the event you need to reschedule or cancel your appointment.
2. If you miss your appointment and do not contact us with proper notice, we will consider this a missed appointment and charge a “no-show” fee of $50.
3. Our office makes reminder calls for initial appointments. It is ultimately the patient's responsibility to remember their scheduled appointments.

CONSENT FOR TREATMENT:

I do hereby consent to and authorize the performance of all examinations, treatments, and medical services deemed advisable by the physicians and staff of the Frank Institute for Health & Wellness to me or to the minor of whom I am the parent or legal guardian. The undersigned is aware that the practice of medicine is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I fully understand this agreement and consent will continue until cancelled by me in writing.

RELEASE OF INFORMATION:

The undersigned hereby authorizes this medical office to disclose all or any part of the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of this medical office's charges or having the responsibility for reviewing such charges, including but not limited to this medical office or medical service organizations, health maintenance organizations, insurance companies, workers compensation claims, welfare funds, or peer review organizations. The undersigned agrees to the copying of all medical record(s) which is/are to be sent to a receiving facility in the event that the undersigned must be transferred to another provider/facility. The undersigned acknowledges and consents that medical records, laboratory results, radiology reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

FINANCIAL AGREEMENT:

The undersigned understands and agrees that the patient and guarantor are financially responsible to Frank Institute for Health & Wellness for charges for medically necessary services or services requested by or on behalf of the patient. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill, or is duly authorized as the patient's general agent to execute the above and accept its terms.

I HAVE READ, OR I HAVE HAD EACH OF THE ABOVE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

________________________________ ____________________

SIGNATURE *DATE*