



1410 Commonwealth Dr #102B,
Wilmington, NC 28403
910.679.8534 (Tel)
910.679.8535 (Fx)

Patient Intake Form

Name _____ Age _____ Birth Date ____/____/____

Sex _____ Address _____

City _____ Zip _____ Phone _____

Email _____

Drivers License # _____ State _____ SSN _____

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

Diabetes: _____ Heart Disease: _____

Stroke: _____ High Blood Pressure: _____

Seizures: _____

Past Medical History:

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

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) _____ Birth Control Pills
- _____ Recreational Drugs _____ Vitamins / Supplements
- _____ Tobacco (cigarettes, cigar, etc.) _____ Herbal Products
- _____ Tobacco (chewing)
- _____ Coffee

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