Print Form

Dr. Susan C. King
1907 Cypress Creek Road Suite 104
Cedar Park, Texas 78613

Welcome To Our Office!

Name:_____ Today's Date:_____
First Middle Last

Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone( )_____ Cell Phone ( )_____
Email Address:_____ May we send information here? Y/N
Birth date:_____ Age:_____ SSN:_____
Employer:_____ Years there_____
Employer's Address_____
City:_____ State:_____ Zip:_____ Occupation:_____
Work Phone ( )_____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party:_____ Relationship to Patient:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone( )_____ Cell Phone ( )_____
Email Address:_____ May we send information here? Y/N
Birth date:_____ Age:_____ SSN:_____
Employer:_____ Years there_____
Employer's Address_____
City:_____ State:_____ Zip:_____ Occupation:_____
Work Phone ( )_____

Name of Spouse:_____ Birth date:_____ Age:_____
Employer:_____ Years there_____
Employer's Address_____
City:_____ State:_____ Zip:_____ Occupation:_____
Work Phone ( )_____ SSN:_____

In case of emergency, contact:_____ Relationship_____
Home Phone ( )_____ Work Phone ( )_____

How did you learn about our practice?_____

Do you wish correspondence to be confidential? YES NO
Do you with phone calls to be confidential? YES NO
May we contact you at work? YES NO

Family Practice New Patient Intake Form

Reason for Visit_____

Past Medical History:

Please review the list below and check any problems you have had now or in the past

Abnormal Pap Smear		Eczema		Osteopenia	
Acne		Emphysema		Osteoporosis	
ADD/ADHD		Frequent UTI's		Positive TB Skin Test	
Alcohol Abuse		Freq Sinus Infections		Prostate Problems	
Anemia		Gallstones		Psoriasis	
Anxiety Disorder		Glaucoma		Reflux (heartburn)	
Asthma		Gout		Rheumatoid Arthritis	
Bipolar Disorder		Heart Attack		Rosacea	
Blood Clot		Heart Condition (specify)		Seasonal Allergies	
Blood Transfusion		Hepatitis (specify A, B, C)		Seizures	
Cancer (What kind)		High Blood Pressure		Sexually Trans. Disease (specify)	
Chronic Bronchitis		High Cholesterol		Stomach Ulcers	
Crohn's Disease or IBS		Kidney Disease		Stroke	
Colon Polyps		Kidney Infections		Tuberculosis	
Depression		Kidney Stones		Thyroid Disease	
Diabetes		Lupus		Ulcerative Colitis	
Diverticulitis		Melanoma or Skin Cancer		Warts	
Drug Abuse		Migraines			
Eating Disorder		Osteoarthritis			

Other medical problem not on list :_____

Please check or list all of the **SURGERIES** you have had:

	Type of surgery:	Year
	Appendectomy	
	Arthroscopy (joint)	
	Back or Neck Surgery	
	Cataract Surgery	
	Cesarean Section	
	Gallbladder Removal	
	Heart Surgery (specify)	
	Hemorrhoids	
	Hernia	

	Type of surgery:	Year
	Hysterectomy	
	Knee or Hip Replacement	
	Mastectomy or Lumpectomy	
	Mastectomy/Lumpectomy	
	Polyp Removal (colon)	
	Tonsillectomy/Adenoidectomy	
	Tubal Ligation or Vasectomy	
	Plastic Surgery (specify)	
	Other (specify)	

Current Medications:

(please include over the counter medications and food **supplements)**

Drug Name:	Dose:	How Often?

Drug Name:	Dose:	How Often?

Are you **ALLERGIC** to any medications? **Yes No**

Drug Name:	Reaction:

NAME: _____

For Women:

Last menstrual period	/ /
Last pap smear n/a	/ /
Last mammogram n/a	/ /
Last bone density	/ /

Age of first period	
# of days in cycle	
# of days in flow	
Are you menopausal	Y N
Age at onset of menopause	

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

Family History: Have any of your family members had any of the following problems?

X	Condition:	Family Member:
	Heart Disease/attack	
	Stroke	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid Disease	
	Depression	
	Other Mental Illness	
	Alcoholism	
	Asthma	

X	Condition:	Family Member:
	Osteoporosis	
	Migraines	
	Breast Cancer	
	Colon Cancer	
	Prostate Cancer	
	Lung Cancer	
	Ovarian Cancer	
	Uterine Cancer	
	Skin Cancer	
	Other Cancer	

Any other illness in the family not listed?

_____

Social History:

Marital Status (circle one): Single Engaged Married Separated Divorced Widowed
Highest Level of Education: <6th grade Jr. High High School College Graduate school Professional

Occupation:

_____

If you have any children, please list their names and ages:

_____

Health Habits:

1. Do you **smoke currently?** Yes No If so, how much? ___ cig/d # of years smoking

___

If no, did you **smoke in the past? Yes No** How many years? __ How much? ___pk/d quite date

_____

Are you **exposed to smoke? Yes No**
Any other **tobacco use? Yes No** type: **Cigars chewing tobacco snuff other**

2. Do you drink **caffeine?** **Yes** **No** If so, how much?

_____

3. Do you drink **Alcohol?** **Yes** **No** What kind? Beer Wine Liquor Other:_____

If so, how many times per week? _____ month? _____ year? _____

Have you ever had a problem with alcohol in the past? (legal or social)

_____

4. Have you ever used **street drugs? Yes No**

Which ones? Marijuana IV drugs amphetamines cocaine heroin downers inhalants other _____

Are you still using? **Yes** **No** Which ones? _____

5. Are you **sexually active** (in the last year)? **Yes No**

If yes circle all that apply: **1 partner** **multiple partners**

Male partner(s) **Female partner(s)**

Which birth control do you or your partner use? None condoms the pill vasectomy/tubal other_____

6. Do you **exercise**? **Yes** **No** If so, what type and how often?

_____

7. Do you eat out at **restaurants** weekly? **Yes** **No** Times per week _____

8. How many servings of **fruits and vegetables** do you get per day? 0 1 2 3 4 5 >5

9. Do you take a **calcium supplement**? **Yes** **No** Number of dairy servings per day: ___ (milk cheese yogurt..)

10. Do you wear a **seatbelt**? **Yes No**

11. Do you have a **living will** (do not resuscitate, medical power of attorney)? **Yes** **No** Please ask for info

12. Is there concern for your **safety?** (emotional, physical, or sexual abuse)? **Yes** **No**

NAME: _____

Dr. Susan C. King
Insurance Information

Patient's Name_____ Today's date _____
First Middle Last

[Primary Insurance]
Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

[Secondary Insurance]
Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

Did your injury happen on the job? Yes No

If yes, on what date did the injury occur? _____
Did you report the accident to your employer? Yes No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co pay, and non-covered service amounts. See our complete financial policy for details.

I authorize the release of any medical information necessary to process my claim. **Initial:** _____

I authorize payment of medical and surgical benefits to Specialists in Family Medicine. **Initial:**_____

Signature of Patient/Legal Guardian: _____Date: _____

Assignment of Benefits

I hereby assign to Susan C King MD, any insurance or other third-party benefits available for health care services provided to me. I understand that Dr. King has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Dr. King, I agree to forward Susan King MD all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____

Date: _____

Consent to Treat

I (or my legal guardian or parent) authorize Dr. Susan King, to provide medical care reasonable by today's standards.

Patient Name: _____ Date of Birth: _____
Signature of Patient/Legal Guardian: _____

Date: _____

Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

a basis for planning my care and treatment
a means of communication among the many health professionals who contribute to my care
a source of information for applying my diagnosis and surgical information to my bill
a means by which a third-party payer can verify that services billed were actually provided
and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and will be provided by request a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:
____ Accepted _____ Denied

Signature **X** _____
Date: _____

Signature of Patient or Legal Representative Witness_____

Date Notice Effective Date or Version_____