Vantage
Medical Associates, P.C.

New Patient Information Intake Form

Thank you for your interest in being a patient of Vantage Medical Associates, P.C. This form is used to collect information about new patients and used for internal purposes only. The information you supply is confidential and will be treated accordingly

Patient Information:

First Name:

Last Name:

Date of Birth:

Gender:

Male Female Other

Street Address:

City:

State:

ZIP Code:

Home Phone:

Mobile Phone:

Social Security Number:

E-Mail:

Primary Language:

English Spanish Other:

Marital Status:

Single Married Divorced Separated Widowed

Spouse Name:

Spouse Phone:

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Emergency Contact:

Emergency Contact Name:

Relationship:

Mobile Phone:

Pharmacy Name:

Phone:

Street Address:

City:

State:

ZIP Code:

Primary Insurance:

Primary Insurance Company:

Group #:

ID #:

Primary Insurance Type:

HMO PPO Medicare Other

Complete the following if you are not the policyholder for your primary insurance

Insurance Policyholder:

Spouse Child Parent Other:

Policyholder Name

Date of Birth:

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Policy holder social security number:

Secondary Insurance Company:

Group #: ID #:

Primary Insurance Type:

HMO PPO Medicare Other

Complete the following if you are not the policyholder for your secondary insurance

Insurance Policyholder:

Spouse Child Parent Other:

Policyholder Name Date of Birth:

Medical History:

Have you ever had any of the following?

Condition	Y	N	Condition	Y	N
Anemia	Y	N	Hyperlipidemia	Y	N
Arthritis Conditions	Y	N	Hypertension	Y	N
Asthma	Y	N	Male Hypogonadism	Y	N
Atrial Fibrillation	Y	N	Hypothyroidism	Y	N
Bleeding Problems	Y	N	Infection Problems	Y	N
Benign Prostatic Hyperplasia	Y	N	Insomnia	Y	N
Coronary Artery Disease	Y	N	Irritable Bowel Syndrome	Y	N
Cancer	Y	N	Kidney Problems	Y	N

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Condition			Condition		
Cardiac Arrest	Y	N	Menopause	Y	N
Celiac Disease	Y	N	Migraines/Headaches	Y	N
Chest Pain	Y	N	Neuropathy	Y	N
Congestive Heart Failure	Y	N	Onychomycosis	Y	N
Chronic Fatigue Syndrome	Y	N	Organ Injury	Y	N
Depression	Y	N	Pulmonary Embolism	Y	N
Diabetes	Y	N	Seizure Disorders	Y	N
Drug/Alcohol Abuse	Y	N	Shortness of Breath	Y	N
Erectile Dysfunction	Y	N	Sinus Conditions	Y	N
Fibromyalgia	Y	N	Stroke	Y	N
Gerd	Y	N	Syndrome X	Y	N
Heart Disease	Y	N	Tremors	Y	N
Hyperinsulinemia	Y	N	Wheat Allergy	Y	N

List any other medical problems that you have had:

List any major conditions / illnesses that your immediate family members have had:

Relative	Condition	Living?	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Other		Y N	
Other		Y ☐ N	

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List the medications you are currently taking including the dosage:

Medication:	Dose:

List your allergies and describe the reactions to your body:

Allergy:	Reaction:

By signing below, I hereby acknowledge, agree, and authorize all of the following:

a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.

b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.

c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) or insurances billing purposes I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.

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d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.

f) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

g) Controlled Substances. I understand that controlled substances of any kind will not be prescribed by any provider at Vantage Medical Associates P.C. unless the patient is an established patient in this office. at least 90 days. According to the provider's assessment, they will determine whether it is medically necessary to give you prescriptions for controlled medications, and there is no guarantee that the prescription for controlled medications will be written I also understand that there are no considerations or exceptions that I owe this and that if I need any special type of drug managed I will accept the provider's decision to refer me to another medical site outside this office.

Patient Signature: ______________________ **Date:** ______________________

Print Name: ______________________

Employee Signature (witness): ______________________