Patient Intake Form

Belred Family Medicine PLLC dba Advanced Family Medicine PLLC

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1. Patient Information

- **Full Name:** _____ **Date of Birth:** _____
- **Preferred Name/Pronouns:** _____ **Gender (Legal):** _____
- **Address:**

  _____
- **Phone Number:** _____ **Email:** _____
- **Occupation/Employer:**

  _____

Primary Emergency Contact

Name:_____**Phone:**_____

Authorized Contact Information

I, the undersigned, understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have the right to authorize the release of my Protected Health Information (PHI) to designated family members, friends, or caregivers.

- **Full Name:** _____
- **Relationship:** _____
- **Primary Phone:** _____
- **Does this person hold your Healthcare Power of Attorney?** [ ] Yes [ ] No

2. Insurance

- **Primary Insurance:** _____ **Policy ID:** _____
- **Subscriber Name:** _____ **Relationship:** _____
- **Emergency Contact Name:** _____ **Phone:** _____

3. Reason for Visit

- **What is the primary reason for your visit today?**

  _____

- **Are you experiencing any of the following? (Check all that apply):**
  - [ ] Pain/Discomfort [ ] Fatigue [ ] Fever [ ] Respiratory Issues
  - [ ] Mood Changes [ ] Digestive Issues [ ] Sleep Disturbance
  - Other reasons_____

4. Medical History

Personal History (Have you ever been diagnosed with):[ ] Hypertension [ ] Diabetes [ ] Asthma/COPD [ ] Anxiety/Depression[ ] Heart Disease [ ] Cancer Type: _____[ ] Thyroid Issues [ ] High Cholesterol, other_____

Current Medications:

Please list all prescriptions, over-the-counter meds, and supplements.

1._____ 2. _____

3._____ 4. _____

5._____6._____

Allergies: [ ] No Known Drug Allergies (NKDA)

- **Allergic to:** _____ **Reaction:** _____

5. Social & Family History

- **Tobacco Use:** [ ] Never [ ] Former [ ] Current Freq: _____
- **Alcohol Use:** [ ] None [ ] Occasional [ ] Daily
- **Family Medical History:**
  - **Mother:**

    _____
  - **Father:**

    _____
  - **Siblings:**

    _____

6. Pharmacy Preference

- **Local Pharmacy Name:**

  _____
- **Online/Mailorder Pharmacy**_____

Signature: _____ **Date:** _____