Northeastern Ohio Infectious Disease Association, Inc.

PATIENT INTAKE FORM

TODAY'S DATE:_____

REFERRED BY DR.:_____

ALLERGIES:_____

PATIENT INFORMATON

NAME: _____ SSN: _____ BIRTH DATE: _____

AGE: _____ SEX: _____ ETHNIC GROUP: _____

ADDRESS: _____ COUNTY: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ MARITAL STATUS: _____

OCCUPATION: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____

RELIGION: _____ VETERAN (YES/NO): _____

DIABETIC (YES/NO): _____

NEAREST RELATIVE INFORMATION (SPOUSE/PARENT)

NAME: _____ RELATION: _____

HOME PHONE: _____ WORK PHONE: _____

Northeastern Ohio Infectious Disease Association, Inc.

REASON FOR VISIT: _____

_____

I. OPERATIONS (SURGERIES)

	TYPE	DATE	WHERE
1.			
2.			
3.			
4.			

II. HOSPITALIZATION (OTHER THAN OPERATIONS)

	FOR WHAT	DATE	WHERE
1.			
2.			
3.			
4.			

III. ALLERGIES (CHECK ALL THAT APPLY)

PENICILLIN _____ OTHER ANTIBIOTICS OR CHEMICALS _____
POLLENS _____ TETANUS _____ EGGS _____
OTHER (SPECIFY) _____

IV. PRESENT MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

V. PAST ILLNESSES (PLEASE CHECK)

TUBERCULOSIS	_____	STROKE	_____	LIVER DISEASE	_____
DIABETES	_____	HEART DISEASE	_____	CANCER	_____
RHEUMATIC FEVER	_____	THYROID DISEASE	_____	PNEUMONIA	_____
HIGH BLOOD PRESSURE	_____	EPILEPSY	_____	KIDNEY DISEASE	_____
ASTHMA	_____	GLAUCOMA	_____	SEVERE INJURY	_____
BLEEDING DISORDER	_____	GOUT	_____	TRANSFUSIONS	_____
MIGRAINE HEADACHES	_____	NERVOUS BREAKDOWN OR MENTAL ILLNESS)			_____

VI. MENSTRUAL HISTORY (FEMALES ONLY)

FIRST DAY OF LAST MENSTRUAL PERIOD: _____ REGULAR: (YES/NO) _____

TOTAL NUMBER OF PREGNANCIES: _____ NUMER OF LIVE BIRTHS: _____

NUMBER OF MISCARRIAGES: _____ WHAT TYPE OF BIRTH CONTROL: _____

IF POSTMENOPAUSAL, HAVE YOU HAD ANY BLEEDING? (YES/NO) _____

VII. SOCIAL HISTORY (PLEASE MARK YES/NO)

TOBACCO _____ ALCOHOL _____

VIII. TRAVEL HISTORY (also include foreign travel information)

_____

_____

IX. PETS

_____

_____

X. PHARMACY MOST OFTEN USED

_____

_____

XI. FAMILY HISTORY

HAS ANY BLOOD RELATIVE EVERY HAD:

	YES	NO	WHO
CANCER, INCLUDING LEUKEMIA			
TUBERCULOSIS			
DIABETES			
HEART TROUBLE			
HEART ATTACK			
FEVERS			
RECURRENT INFECTIONS			
ASTHMA			
ALCOHOLISM			
SICKLE CELL ANEMIA			
OTHER SERIOUS DISEASE			

XII. REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

HAVE YOU RECENTLY HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING:

	YES	NO
FREQUENT OR SEVERE HEADACHES		

	YES	NO
DOUBLE VISION		
BLINDNESS (WHICH EYE)		
HIGH CHOLESTEROL		
BLURRED VISION		
WEAR CONTACT LENSES		
GLAUCOMA (HARDENING OF EYEBALL)		
EYE INJURIES, DEFECTS		
BUZZING OR RINGING IN EARS		
LOSS OF HEARING		
EAR INFECTION		
CHRONIC SINUS TROUBLE (SINUSITIS)		
HOARSENESS		
GOITER/THYROID TROUBLE		
ENLARGED GLANDS IN NECK OR OTHER AREA		
STIFFNESS OF NECK		
CHRONIC COUGH		
FREQUENT COLDS		
WHEEZING OR ASTHMA		
PNEUMONIA (WHEN)		
COUGH UP BLOOD		
CHEST PAIN		
RECURRING OR CHRONIC BRONCHITIS		
SHORTNESS OF BREATH		
HEART MURMUR OR LEAKY VALVES		
STOMACH OR INTESTINAL ULCERS		
WEIGHT CHANGE (WHICH WAS NOT PLANNED)		
FREQUENT OR SEVERE NAUSEA OR VOMITING		
VOMITING OF BLOOD		
ECZEMA, HIVES, FUNGUS, RASH		
GALLBLADDER TROUBLE		
RECURRING PAIN IN ABDOMEN (STOMACH)		
FREQUENT DIARRHEA (IF BLOODY USE 2 CHECKS)		
FREQUENT CONSTIPATION		
COLITIS (IF BLOODY USE 2 CHECKS)		
YELLOW JAUNDICE		
KIDNEY OR BLADDER INFECTION		
KIDNEY OR BLADDER STONE		
BLOODY URIN		
LOSS OF BLADDER CONTROL		

	YES	NO
TROUBLE PASSING URINE (PAIN OR FREQUENCY)		
SEXUALLY TRANSMITTED DISEASE (SYPHILIS/GONORRHEA)		
SWELLING OF FEET OR ANKLES		
ENLARGED OR VARICOSE VEINS		
PHLEBITIS (“MILK LEG”)		
ARTHRITIS (ANY KIND OF RHEUMATISM OR BURSITIS)		
SWOLLEN, STIFF OR PAINFUL JOINTS		
FRACTURE (BROKEN) BONE (WHICH)		
AMPUTATION (WHERE)		
BACK INJURY OR CHRONIC BACK PAIN		
RUPTURED (SLIPPED) DISC		
PILONIDAL OR OTHER CYSTS		

Northeastern Ohio Infectious Disease Association, Inc.

AUTHORIZATION & AGREEMENTS

PERMISSION FOR TREATMENT:

The undersigned has been informed and does herein consent to such diagnostic, operative, or treatment procedures on the patient named below that are deemed necessary or advised by the physician in charge. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.

AUTORIZATION FOR RELEASE OF INFORMATION:

It is understood that medical and financial records of their treatment may be disclosed to the insurance company(ies) providing or considering payment arising from this treatment and hospital visit (including Medicare, Medicaid, or Health Plan Administrators or their representatives, including any review agencies or committees).

PHOTOPGRAPHY CONSENT:

I hereby consent and authorize Northeastern Ohio Infectious Disease Association, Inc., employees, and its independent contractors to take photographs to document my clinical condition or in efforts to provide medical treatment. These photos may be used for purposes of teaching medical students and/or colleagues.

GUARANTEE OF ACCOUNT:

I understand I am financially responsible to the hospital for charges not covered by this authorization.

AGREEMENT TO PAY FOR HEALTHCARE BILLING & SERVICES:

I agree to pay for any and all services rendered by Northeastern Ohio Infectious Disease Association, Inc. (NEOIDA) and its independent contractors. It is understood that NEOIDA reserves the right to transfer unpaid bills to a collection agency or an attorney. I understand that if payments are late or delinquent legal action may be taken and I agree to have interest applied to any and all late or delinquent bills at 6% interest.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment of the benefits otherwise payable to me, by the designated insurance company, directly to the above-named physician (physician services or hospital).

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PHYSICIAN, FACILITY, AND PATIENT:

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Anthony F. Cutrona, M.D., FACP, or Northeastern Ohio Infectious Disease Association, Inc. I authorize any holder of medical and other information needed to determine these benefits for related services.

Northeastern Ohio Infectious Disease Association, Inc.

AUTHORIZATION & AGREEMENTS

SIGNATURE PAGE

PATIENT SIGNATURE X_____

SIGNATURE OF PARENT OR LEGAL GUARDIAN (IF APPLICABLE)

X_____

RESPONSIBLE PARTY X_____

DATE _____ TIME_____

WITNESSED BY _____

(PLEASE SIGN BOTH X'S)

Northeastern Ohio Infectious Disease Association, Inc.

MEDICAL RECORD RELEASE

I, _____ hereby authorize release of my medical records to Northeastern Ohio Infectious Disease Association, Inc. from the below-mentioned doctor, hospital, or long-term care facility.

NAME OF DOCTOR/FACILITY

_____

_____ _____

DATE SIGNATURE