Patient Intake Form

Today's Date: _____/_____/_____

Patient Name: ____ **Date of Birth**:_____/_____/_____

Doctor or PA that you are seeing today:____

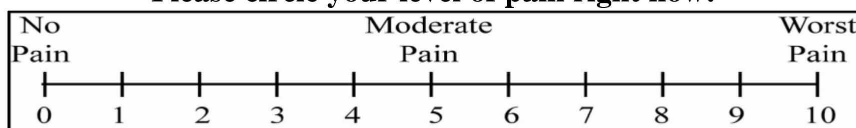
Primary Care Doctor, PA/Nurse Practitioner:____

Referring Doctor, PA/Nurse Practitioner:____

Reason for Today's Visit: ____
(*which side? right, left, both*)

Email Address: None ☐ **On File** ☐ ____

Please circle your level of pain right now:



Did you receive the influenza vaccine in the current flu season (September through March)? ☐ Yes

Or, did you receive the influenza vaccine last flu season? ☐ Yes

If you did NOT receive the influenza vaccine, was it:

☐ due to patient allergy
☐ because patient refused
☐ because (other) ______________________________

ATTENTION PATIENTS 65 AND OLDER:

Have you ever received a pneumonia vaccine? ☐ No ☐ Yes

Do you have a Living Will or Advance Directive? ☐ No ☐ Yes

If yes, please name responsible person: ____

Please complete, take this form with you for your appointment, and return to desk #5 or #6 when you are checking-out after your appointment. Thank you!

OFFICE USE ONLY

FOLLOW UP: ______DAY(S) ______WEEK(S) ______MONTH(S) ______YEAR(S)

WITH ______________________________ (IF DIFFERENT THEN PROVIDER PT SAW TODAY)

Form PP-705B 11/15/2018 jj