PRIMARY CARE PROVIDERS OF CHICAGO
Your partner in health

PATIENT INTAKE FORM

PATIENT INFORMATION

Full Name : ______________________ Date Of Birth : D D M M Y Y

Email Address : ______________________ Sex : ☐ Male ☐ Female

Address : ______________________

Home Phone : ______________________ Cell : ______________________

Marital Status : ______________________ Social Security Number : ☐☐☐ ☐☐ ☐☐

Occupation : ______________________ Retired? ☐ Employer : ______________________

Employer Address : ______________________

Communication Preference (for Appts, Rx Notices, Test Results) : ☐ Phone ☐ Text (SMS) ☐ Both

Pharmacy Name (Primary) : ______________________ Phone : ______________________

Address : ______________________

HEALTH INSURANCE

Name of Primary Insured/Responsible Party : ______________________

Primary Insurance: ______________________ Are you the Policy Holder? ☐

Secondary Insurance: ______________________ Are you the Policy Holder? ☐

Policy Holder Information (If Required)

Full Name : ______________________ Date Of Birth : D D M M Y Y

Relationship to Patient : ______________________ Phone : ______________________

Address : ______________________

Employer : ______________________ Last 4 Digits of SSN : ☐☐☐☐

Employer Address : ______________________

I was referred to this practice by : ______________________

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MEDICAL HISTORY

Full Name :

Today's Date : D D M M Y Y

MEDICAL DIAGNOSES:

PAST SURGERIES:

ALLERGIES:

CURRENT MEDICATIONS: (Please include full name, dosage, and number of times taken in a day)

PREVIOUS HOSPITALIZATION/S: (Please include the year and reason of hospitalization/s)

FAMILY MEDICAL HISTORY: (Please include diagnosis and relationship to the patient)

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PERSONAL HABITS

DO YOU SMOKE? ☐ Yes **HOW MANY PACKS PER DAY?** ☐ 0.25 ☐ 0.5 ☐ 1 **FOR HOW MANY YEARS?** ____

DO YOU DRINK? ☐ Yes **HOW MANY DRINKS PER DAY?** ____ **FOR HOW MANY YEARS?** ____

ADDITIONAL INFORMATION

If you have any additional information that you would like to share with us, please list it below.

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CONSENTS

1. **HIPPA RELEASE INFORMATION-** I hereby give permission for the person (s) listed below to receive information about my health records:

Name ______________ **Relationship** ______________ **Phone** ______________

Name ______________ **Relationship** ______________ **Phone** ______________

2. **CONSENT TO RECEIVE TEXT/EMAIL MESSAGES:** I hereby give consent to Primary Care Providers of Chicago to transmit administrative information via texts/emails such as appointment reminders and other announcements.

3. I hereby acknowledge that I have received a copy of the **Notice of Privacy Policy, Financial Policy,** and **No Show/Cancellation Policy**. (Located in attached documents)

SIGN BELOW TO AUTHORIZE **ALL THREE** CONSENTS AND THE POLICIES MENTIONED ABOVE:

Signature: ______________ **Date:** ______________

For More Information:

7447 W Talcott Ave Suite 216

+1 773-631-0566

www.pcpofchicago.com

THANK YOU FOR CHOOSING PCP