

**PATIENT INFORMATION FORM** Today's temperature: \_\_\_\_\_

Name (last, first, middle): \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_  preferred call method  
 Cell Phone: \_\_\_\_\_  preferred call method

Email Address: \_\_\_\_\_ C DO NOT enroll me in the online health portal

Gender: Male / Female Marital Status: Single / Married / Widowed / Divorced / Separated

Occupation: \_\_\_\_\_ Work Status: Employed / Unemployed / Retired / Disabled

**Race (please check one)**

- Not specified /
- Other
- Native American or
- Alaskan Native
- Asian
- Black or African
- American
- Hawaiian Native or
- Other Pacific
- Islander
- White

**Ethnicity (please check one)**

- Not specified / Other
- Hispanic or Latino
- Not Hispanic or Latino

Preferred Language: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone  
 Number: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Reason for Today's Visit:** \_\_\_\_\_

**Emergency Contact**

Name (last, first, middle): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ home / cell Email Address: \_\_\_\_\_

Name (last, first, middle): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ home / cell Email Address: \_\_\_\_\_

*\*Please bring a copy of your driver's license and health insurance card, if applicable, with you to every visit.*



4200 Little Blue Pkwy. Suite 350  
Independence, MO 64057  
816-648-6482 phone | 855-618-2442 fax

**Communication Preferences**

MIVA Medical contacts patients for a variety of reasons, including appointment reminders and providing test results. Please let us know how you prefer us to communicate with you.

Please DO NOT contact me at the following (check all that apply):

Cell Phone

- Reminder Calls
- Voicemail
- Text Reminders - SMS (standard charges may apply)

Home Phone

- Reminder Calls
- Voicemail

Patient Portal

- Appointment Reminders
- General Notifications

**Patient Consent to Release Protected Health Information**

Authorized by:

Patient \_\_\_\_\_ Legal Guardian/POA: \_\_\_\_\_

Disclose my Protected Health Information to:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

This authorization is in force until:

\_\_\_ It is cancelled in writing

\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship to Patient

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### Insurance Information

**PLEASE HAVE YOUR PHOTO ID & INSURANCE CARDS AT EVERY VISIT. ALL COPAYS ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

#### Primary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

#### Secondary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

#### Tertiary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

\_\_\_\_\_  
 Patient Name (Please Print)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
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**Surgical History**

Surgery	Year	Location/Facility

**Prior Anesthesia Complications?**

No     Yes; Please explain: \_\_\_\_\_

**Personal Medical History**

Please check any of the following health problems you have had or have now:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Stroke or Mini Stroke	<input type="checkbox"/> Emphysema (COPD)	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Pain in legs with walking	<input type="checkbox"/> Stomach Reflux/Heartburn	<input type="checkbox"/> Aneurysm Location: _____
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Problems/Failure	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Diabetes Type: _____
<input type="checkbox"/> Congestive Heart Failure (CHF)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Pacemaker/ICD	<input type="checkbox"/> Bleeding or Clotting Problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> Varicose Veins/Vein Stripping	<input type="checkbox"/> Abnormal Heart Rhythm/Atrial Fibrillation	<input type="checkbox"/> Other: _____

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**Other Health Issues**

Smoking Status:  Never  Quit, when? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_  
 Current Smoker; how many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_  
If current or past, what type?  Cigarettes  Cigars  Pipe  Chewing Tobacco

Do you use any recreational drugs?  No  Yes; which ones? \_\_\_\_\_

Do you drink alcohol?  No  Yes;  Wine  Beer  Liquor How many per week? \_\_\_\_\_

Is violence at home a concern for you?  No  Yes

Do you require the use of:  Cane  Walker  Wheel Chair

**Known Allergies to Food or Medication**  No Allergies

Medical Contrast Dye  Iodine  Choloraprep  Adhesive/Tape  Latex

Allergy and Reaction: \_\_\_\_\_

Allergy and Reaction: \_\_\_\_\_

Allergy and Reaction: \_\_\_\_\_

Allergy and Reaction: \_\_\_\_\_

Allergy and Reaction: \_\_\_\_\_

**Do you take any of the following:**

Coumadin/Warfarin  Xarelto  Clipidogrel/Plavix  Apixaban/Eliquis  Aspirin  Pradaxa

**Preferred Pharmacy**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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**Current Medications**

Please list prescription and non-prescription medications, vitamins, cold remedies and herbals.

Medication Name and Purpose	Dosage (Amount)	Frequency (How often)

**Family Medical History**

Please check if the following health problems affect your family and identify their relationship to you (mother, father, brother, sister, grandparent or child).

<input type="checkbox"/> Alcohol/Drug Abuse _____	<input type="checkbox"/> Emphysema/COPD _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Bleeding Problem _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Blood Clots _____	<input type="checkbox"/> High Cholesterol _____
<input type="checkbox"/> Cancer-Type: _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Cancer-Type: _____	<input type="checkbox"/> Obesity _____
<input type="checkbox"/> Cancer-Type: _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Depression / Anxiety _____	<input type="checkbox"/> Thyroid Problems _____
<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Varicose Veins _____
<input type="checkbox"/> Dialysis _____	<input type="checkbox"/> Other: _____

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**Review of Systems**

Please check all that apply:

	<b>Constitution</b>	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Unexpected weight change
	<input type="checkbox"/> Other: _____	
	<b>Respiratory</b>	
<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Home oxygen	<input type="checkbox"/> Asthma	
	<input type="checkbox"/> Other: _____	
	<b>Cardiovascular</b>	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Myocardial Infarction
	<input type="checkbox"/> Other: _____	
	<b>Gastrointestinal</b>	
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Nausea
	<input type="checkbox"/> Other: _____	
	<b>Genitourinary</b>	
<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Frequency
<input type="checkbox"/> Hematuria	<input type="checkbox"/> Scrotal swelling	<input type="checkbox"/> Urgency
<input type="checkbox"/> Urine decreased	<input type="checkbox"/> Other: _____	

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<b>Musculoskeletal</b>		
<input type="checkbox"/> Arthralgias	<input type="checkbox"/> Back pain	<input type="checkbox"/> Joint swelling
	<input type="checkbox"/> Other: _____	
<b>Skin</b>		
<input type="checkbox"/> Color change	<input type="checkbox"/> Rash	<input type="checkbox"/> Wound
	<input type="checkbox"/> Other: _____	
<b>Neurological</b>		
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Light-headedness
	<input type="checkbox"/> Other: _____	
<b>Hematological</b>		
<input type="checkbox"/> Adenopathy	<input type="checkbox"/> Bruises/bleeds easily	<input type="checkbox"/> Anemia
	<input type="checkbox"/> Other: _____	

**GYN (Females Only)**

Date of Last Menstrual Cycle: _____	Age of First Menstruation: ____ Age of Menopause: ____
Total Number of Pregnancies: _____	Number of Live Births: _____
Pregnancy Complications: _____	

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