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

**PATIENT INFORMATION FORM** **Today's temperature:_____**

Name (last, first, middle): _____

DOB: _____/_____/_____ Social Security Number: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____
☐ preferred call method ☐ preferred call method

Email Address: _____ ☐ 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: _____

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**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

_____ _____
Patient/Guardian Signature Relationship to Patient

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Patient Name: _____ DOB: _____

## 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:

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

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Patient Name: _____ DOB: _____

**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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Patient Name: _____ DOB: _____

## 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).

| | |
|---|---|
| ☐ Alcohol/Drug Abuse _____ | ☐ Emphysema/COPD _____ |
| ☐ Asthma _____ | ☐ Heart Disease _____ |
| ☐ Bleeding Problem _____ | ☐ High Blood Pressure _____ |
| ☐ Blood Clots _____ | ☐ High Cholesterol _____ |
| ☐ Cancer-Type: _____ | ☐ Kidney Disease _____ |
| ☐ Cancer-Type: _____ | ☐ Obesity _____ |
| ☐ Cancer-Type: _____ | ☐ Stroke _____ |
| ☐ Depression / Anxiety _____ | ☐ Thyroid Problems _____ |
| ☐ Diabetes Type:_____ _____ | ☐ Varicose Veins _____ |
| ☐ Dialysis _____ | ☐ Other: _____ |

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Patient Name: _____ DOB: _____

**Review of Systems**
Please check all that apply:

| | | |
|---|---|---|
| | **Constitution** | |
| ☐ Fatigue | ☐ Fever | ☐ Unexpected weight change |
| | ☐ Other: _____ | |
| | | |
| | **Respiratory** | |
| ☐ Chest tightness | ☐ Cough | ☐ Shortness of breath |
| ☐ Home oxygen | ☐ Asthma | |
| | ☐ Other: _____ | |
| | | |
| | **Cardiovascular** | |
| ☐ Chest pain | ☐ Leg Swelling | ☐ Palpitations |
| ☐ Congestive Heart Failure | ☐ Arrhythmia | ☐ Myocardial Infarction |
| | ☐ Other: _____ | |
| | | |
| | **Gastrointestinal** | |
| ☐ Abdominal pain | ☐ Blood in stool | ☐ Nausea |
| | ☐ Other: _____ | |
| | | |
| | **Genitourinary** | |
| ☐ Difficulty urinating | ☐ Dysuria | ☐ Frequency |
| ☐ Hematuria | ☐ Scrotal swelling | ☐ Urgency |
| ☐ Urine decreased | ☐ Other: _____ | |

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| | | |
|---|---|---|
| | **Musculoskeletal** | |
| ☐ Arthralgias | ☐ Back pain | ☐ Joint swelling |
| | ☐ Other: _____ | |
| | | |
| | **Skin** | |
| ☐ Color change | ☐ Rash | ☐ Wound |
| | ☐ Other: _____ | |
| | | |
| | **Neurological** | |
| ☐ Dizziness | ☐ Headaches | ☐ Light-headedness |
| | ☐ Other: _____ | |
| | | |
| | **Hematological** | |
| ☐ Adenopathy | ☐ Bruises/bleeds easily | ☐ Anemia |
| | ☐ 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: _____ | |

_____ _____
Patient Name (Please Print) Date

_____ _____
Patient/Guardian Signature Relationship to Patient

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