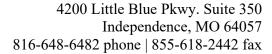




PATIENT INFORMATION F	ORM Today's temperature:		
Name (last, first, middle):			
DOB:/	Social Security Number:		
Street Address:			
City/State/Zip:			
Home Phone:preferred call method	Cell Phone: preferred call method		
Email Address:	C DO NOT enroll me in the online health portal		
Gender: Male / Female	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	Ethnicity (please check one) Not specified / Other Hispanic or Latino Not Hispanic or Latino		
Asian Black or African American Hawaiian Native or Other Pacific Islander White	Preferred Language:		
Number:	Primary Care Physician: Pho		
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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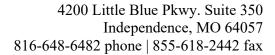


Communication Preferences

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 N Cell Phone	OT contact me at the following	g (check all that apply):	
	Reminder Calls		
] Voicemail		
Home Phone	Text Reminders - SMS (standard o	charges may apply)	
	Reminder Calls		
Patient Portal	J Voicemail		
	Appointment Reminders		
	General Notifications		
Patient Con	sent to Release Protected H	ealth Information	
Authorized l	by:		
Patient		Legal Guardian/POA:	
Disclose my	Protected Health Information	to:	
Name:		Phone:	_ Relationship:
Name:		_ Phone:	_ Relationship:
Name:		Phone:	_ Relationship:
	zation is in force until: celled in writing		
Other: _			
Patient Name (Ple	ase 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.

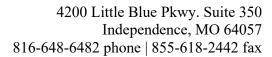
Primary Insurance		
Insurance Carrier:	Effective Date:	
Member ID:		
Group:		
Policy Holder Name:	Policy Holder DOB:	
Policy Holder SSN:	Policy Holder Employer:	
Secondary Insurance		
Insurance Carrier:	Effective Date:	
Member ID:		
Group:		
Policy Holder Name:	Policy Holder DOB:	
Policy Holder SSN: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

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Patient Name:	DOB:	-	
Surgical History			
Surgery		Year	Location/Facility
Personal Medical History Please check any of the following healt	ch problems you have had or have now	☐ Thyroid	Problems
☐ High Cholesterol	□ Pneumonia	☐ Seizure Disorder	
☐ Stroke or Mini Stroke	☐ Emphysema (COPD)	☐ Stomach Ulcers	
☐ Pain in legs with walking	☐ Stomach Reflux/Heartburn	☐ Aneurysm Location:	
☐ Heart Attack	☐ Kidney Problems/Failure	☐ HIV/AIDS	
□ Angina/Chest Pain	□ Prostate Problems	☐ Diabetes	
☐ Congestive Heart Failure (CHF)	☐ Hepatitis	□ Asthma	
□ Pacemaker/ICD	☐ Bleeding or Clotting Problems	☐ Anemia	
☐ Varicose Veins/Vein Stripping	☐ Abnormal Heart Rhythm/Atrial Fibrillation	□ Other:	

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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? \square No \square Yes; which ones?
Do you drink alcohol? ☐ No ☐ Yes; ☐ Wine ☐ Beer ☐ Liquor How many per week?
Is violence at home a concern for you? \square No \square Yes
Do you require the use of: $\ \square$ Cane $\ \square$ Walker $\ \square$ Wheel Chair
Known Allergies to Food or Medication □ No Allergies
☐ Medical Contrast Dye ☐ Iodine ☐ Choloraprep ☐ Adhesive/Tape ☐ Latex
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 rem	edies and	herbals.
Medication Name and Purpose	Dosage (Ar	mount)	Frequency (How often)
Family Medical History Please check if the following health problems father, brother, sister, grandparent or child).	affect your family and identify t	their relati	onship to you (mother,
☐ Alcohol/Drug Abuse	□ Emphysema/C	COPD .	
□ Asthma	Heart Disease		
☐ Bleeding Problem	☐ High Blood Pressure		
□ Blood Clots	☐ High Cholesterol		
☐ Cancer-Type:	☐ Kidney Disease		
☐ Cancer-Type:			
☐ Cancer-Type:			
□ Depression / Anxiety		ems	
□ 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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	Muscu	loskeletal	
☐ Arthralgias	☐ Back pain		☐ Joint swelling
	□ Other:		
		Skin	
□ Color change	□ Rash		□ Wound
	□ Other:		
	Neur	ological	
□ Dizziness	☐ Headaches		☐ Light-headedness
	□ Other:		
	Hema	tological	
☐ Adenopathy	☐ Bruises/bleed	s easily	□ Anemia
	□ Other:		
	GYN (Fem	ales Only)	
Date of Last Menstrual Cycle:		Age of First Menstruation: Age of Menopause:	
Total Number of Pregnancies:		Number of Live Births:	
Pregnancy Complications:		_	
atient Name (Please Print)			 Date
adent Hame (1 lease 1 lint)			Date
atient/Guardian Signature			Relationship to Patient

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