Information

Patient Name *

First Name

Middle Name

Last Name

Address *

Address

City

State

Zip

Email Address *

@

Cell Phone *

(000) 000-0000

Home Phone

(000) 000-0000

Pharmacy Preference

Pharmacy Preference

Reason for your visit today *

Reason

How did you hear about us?

Referring Doctor | Friend | Online Search | Facebook

Please indicate if you have had any of the following:

- [ ] ADD/ADHD
- [ ] Alcoholism
- [ ] Anemia
- [ ] Chronic Fatigue
- [ ] Cosmetic Surgery
- [ ] Heart Murmur
- [ ] Heart Surgery
- [ ] Hepatitis
- [ ] Low Blood Pressure
- [ ] Seizures
- [ ] Sleep Apnea
- [ ] Stroke

List any medications (prescription or non-prescription), vitamins, or supplements you are currently taking.

Are you currently in pain? If yes what would you rate the pain on a scale of 1-10?

Yes | No

Non Medication Allergies:

Non Medication Allergies

Medication Allergies

Yes

No known drug allergies

Past Surgical History

Please list month and year of procedure.

- [ ] **History of problem with anesthesia**
- [ ] **Ear surgery (eg. Ear tubes, Ear drum repair, Mastoid surgery)**
- [ ] **Nasal surgery (eg. Septoplasty, Turbinate reduction, rhinoplasty)**
- [ ] **Sinus surgery (eg. Balloon sinuplasty, sinus surgery, polyp removal)**
- [ ] **Throat surgery (eg tonsils, adenoids, UPPP)**
- [ ] **Neck surgery (eg. Thyroid, carotid surgery, tracheostomy)**
- [ ] **Other (eg. Appendix, cataracts, gallbladder, heart surgery, heart stents, hemorrhoids, hernias)**

Family History

Have any family members been diagnosed with any of the following? Please select all appropriate.

- [ ] Allergy
- [ ] Asthma
- [ ] Bleeding/clotting
- [ ] Diabetes
- [ ] Hearing loss before 50
- [ ] Heart Disease
- [ ] Heart attack
- [ ] Anesthesia problem
- [ ] Stroke
- [ ] Cancer
- [ ] Other

Signature

Clear Undo

Vital Care Primary and Urgent Care

Vital Care New patient intake

Upload Cards

Insurance Information

Do you have insurance?

Yes No

Do you have secondary insurance?

Yes No

Photo ID

Upload Photo ID

Front Back

Upload Insurance Card

Front Back

HIPAA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may

include PHI by government agencies or insurance payers in normal perfor.ıaı of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attenti of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or vertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, First Name Last Name, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward

Patient/ Client First Name *

First Name

Patient/Client Last Name *

Last Name

Patient/Client Signature *

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Date

August 06 2025

Medical Consent Form

I, ***[firstName] [lastName]***, do hereby agree and give my consent to the physician to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental condition. I understand my physician may utilize a nurse to assist with my plan of care.

Signature

Clear Undo

Patient Name * Required

First Name

Last Name