Senior Health First
Centura Health

Welcome to Senior Health First. We are glad to have you join our practice. We specialize in providing *comprehensive, coordinated care* for seniors who are recipients of Medicare and other Medicare Advantage Plans. Our team of dedicated medical professionals will partner with you to achieve the highest quality of health care to support you.

Please take a few minutes of your valuable time to fill out our new patient forms. **You will need to return this packet either by mail or in person at least one week prior to your scheduled appointment. Your doctor must have this information available to review with you on the first visit.** It will enable your physician to put together a care plan that addresses all of your medical concerns and issues. If you have a question about any part of the form or are uncertain about any of the information, we can help you when you check in or contact the office to discuss questions.

You will need to check in 30 minutes before your scheduled appointment time with your new doctor so we can review any questions and have time to complete new patient forms and paperwork. Please bring your insurance cards and photo ID as well, so we make sure we have the correct information for billing purposes.

Senior Health First clinics are hospital based clinics and patients may receive a facility fee along with the professional provider charges on one bill from Centura Health. Please contact your health insurance provider directly if there are questions regarding your bills.

And one final request, please bring all of your medication pill bottles with you to the appointment. Your new doctor wants to review your current medications and having the medication bottles with you is the best way to assure accuracy. We will provide you with an After Visit Summary at the end of your visit for you to take home. The After Visit Summary will include details of your appointment, medications and your next scheduled appointment. If you or your family member has an email address, we will invite you to join our patient portal called MyChart. We can assist you to sign up for the portal at the end of your visit. Accessing the portal allows direct communication with the clinic and your care team. You may also be able to view lab results and procedure reports.

Thank you for choosing Senior Health First as your primary care medical practice. We look forward to getting to know you and to become your partner in managing your healthcare needs.

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New Patient Information
SEN-009 rev. 06/16

NEW PATIENT INFORMATION

Name: _____ SSN: _____
Last First MI

Sex: ☐ M ☐ F DOB: _____ Preferred Name: _____

Address: _____

_____
City State Zip

Mailing address: ☐ Check if same as above

_____
Address

_____
City State Zip

Home Phone: _____ Cell: _____

Email: _____

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant Other ☐ Single ☐ Widowed ☐ Declined

Would you prefer to speak to your healthcare provider through a translator? ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Other (please specify): _____ Written Language: _____

Religion: _____ ☐ Declined Birthplace: _____

Ethnicity: Do you consider yourself to be Hispanic or Latino? ☐ Yes ☐ No ☐ Declined

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ White
☐ Black or African American ☐ Asian ☐ Declined

Patient Employment Information: _____ Employer Phone: _____ Occupation: _____

Status: ☐ Part-time ☐ Full-time ☐ Self-Employed ☐ Retired ☐ Active Military ☐ Disabled ☐ Student
☐ Unemployed ☐ Unknown

PHARMACY	**Address/Cross Streets**	**Phone Number**	**Preferred**
Local: _____	_____	_____	☐
Alternative: _____	_____	_____	☐
Mail Order: _____	_____	_____	☐

CARE TEAM

Current Primary Care Physician: _____ Practice Name _____ Phone Number: _____

Current Specialist Name: _____ Specialty: _____ Phone Number: _____

Current Specialist Name: _____ Specialty: _____ Phone Number: _____

NEXT OF KIN ☐ Check if ok to contact

Name: _____ Relation to patient: _____
Last First

Address: _____

Phone: _____

PERSON TO NOTIFY ☐ Check if same as next of kin

Name: _____ Relation to patient: _____
Last First

Address: _____

Phone: _____

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PARTY RESPONSIBLE FOR PAYMENT (GUARANTOR) ☐ Check if same as patient

Name: _____ DOB: _____
Last First mm/dd/yy

Address: _____

_____
City State Zip

Phone: _____

SSN: _____ Relation to patient: _____

Advance Directive

Do you have a Living Will / DNR? ☐ Yes ☐ No

Do you have a Durable Power of Attorney? ☐ Yes ☐ No Do you have a MOST form completed? ☐ Yes ☐ No

If yes: _____
Please Print Name Phone Number

Would you like information regarding Advance Directive? ☐ Yes ☐ No

Signature: _____ Date: _____ Time: _____
(Patient or Authorized Representative)

AUTHORIZATION TO LEAVE TELEPHONE INFORMATION

Centura Health Physician's Group is committed to ensuring the privacy and confidentiality of your medical/personal information. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following information:

Number to best contact you: _____ ☐ Home ☐ Cell ☐ Work

May we leave a clinical message if no answer? ☐ Yes ☐ No

May we leave information with someone other than you regarding your medical care (medication changes, laboratory results, billing issues, appointments, etc.)? If so, please list the name(s) in the space(s) below.

Billing Issues: ☐ Yes ☐ No

Clinical Issues: ☐ Yes ☐ No

Name: _____ Phone: _____ Relation to patient: _____

Name: _____ Phone: _____ Relation to patient: _____

How did you hear about our practice?

☐ Referring Physician _____

☐ Friend/Family: Name: _____

☐ Event: Name: _____

☐ Online/Practice Website ☐ Insurance ☐ Newspaper

☐ Direct Mail ☐ Television ☐ Billboard

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Name: _____ DOB: _____
Last First MI mm/dd/yyyy

ALLERGIES ☐ No Known Drug Allergies
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Other (latex, adhesive, food, environment): _____

MEDICATIONS ☐ None
Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	Dose	How often do you take	Reason for taking medication

PERSONAL MEDICAL HISTORY
Please check all diagnoses that apply to you and add notes as needed.

AIDS	☐ Yes	☐ No	Hepatitis - Type: _____	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Angina (Heart pain)	☐ Yes	☐ No	Hyperlipidemia (High cholesterol)	☐ Yes	☐ No
Arrhythmia/Palpitations	☐ Yes	☐ No	Hypertension (High blood pressure)	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Irritable Bowel Syndrome (IBS)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No	Long-Term Steroid Use	☐ Yes	☐ No
Bleeding disorder/tendency	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	MI (Heart attack) - Date: _____	☐ Yes	☐ No
Bone Loss - DEXA: _____ Date	☐ Yes	☐ No	Motor Vehicle Accident	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Oxygen Use	☐ Yes	☐ No
Chronic Fatigue	☐ Yes	☐ No	Peripheral Artery Disease	☐ Yes	☐ No
Chronic Kidney Disease	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Chronic Pain	☐ Yes	☐ No	Restless Leg Syndrome	☐ Yes	☐ No
Connective Tissue Disorder	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
COPD/Emphysema	☐ Yes	☐ No	Sciatica	☐ Yes	☐ No
CVA/Stroke	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Diabetes - Type:	☐ Yes	☐ No	Seasonal Allergies: _____	☐ Yes	☐ No
Dialysis (hemodialysis or peritoneal)	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Disabilities: _____	☐ Yes	☐ No	Sinusitis, recurrent	☐ Yes	☐ No
Diverticulitis	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Ear Infection, recurrent	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Environmental/Food Allergies: _____	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	UTI (Bladder infections)	☐ Yes	☐ No
Genetic/Congenital Condition: _____	☐ Yes	☐ No	Vertigo	☐ Yes	☐ No
GERD (Heartburn)	☐ Yes	☐ No	Other Conditions: _____		
GI Bleeding	☐ Yes	☐ No	_____		
Glaucoma	☐ Yes	☐ No	_____		
Gunshot Wound	☐ Yes	☐ No	Date of last dental exam: _____		
Head Injury/Concussion	☐ Yes	☐ No	Date of last eye exam: _____		
Hearing Deficit	☐ Yes	☐ No	**Date of Last Colonoscopy:** _____		
Heart Disease	☐ Yes	☐ No	Doctor: _____		
Heart Failure	☐ Yes	☐ No	History of colon polyps	☐ Yes	☐ No

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Name: _____ DOB: _____
Last First MI mm/dd/yyyy

SURGICAL HISTORY

Please list surgeries/procedures and add notes as needed.

Year	Surgery/Procedure	Hospital/Location	Complications/Additional Comments

Have you ever had a reaction to general anesthesia? ☐ Yes ☐ No

Additional Personal Medical History

_____

_____

_____

FEMALE PATIENTS ONLY

☐ Abnormal Pap smear
☐ Other GYN history (indicate below)
Age of first menstrual period: _____
Date of last menstrual period: _____
Age of menopause: _____

Form of contraception (if any): _____
Last mammogram: _____
Last Pap smear: _____
Currently pregnant? ☐ Yes ☐ No
Currently breastfeeding? ☐ Yes ☐ No

Planning pregnancy? ☐ Yes ☐ No
Number of Pregnancies: _____
Number of Deliveries: _____
Number of Elective abortions: _____
Number of Miscarriages: _____

SOCIAL HISTORY

Tobacco Use: ☐ None Quit Date: _____
☐ Pipe/Cigar ☐ Cigarettes Packs/Day: _____ Number of years smoked: _____
☐ Smokeless tobacco ☐ Electronic or E-Cigarette ☐ Secondhand smoke exposure

Alcohol Use: ☐ None ☐ Daily ☐ Occasional ☐ Trying to cut down ☐ In recovery Amount per week: _____

Drug Use: ☐ None ☐ Past Use ☐ Current
How many times in the past year have you used recreational drugs or prescription medication for nonmedical reasons?
☐ None ☐ One or more
☐ Marijuana ☐ Amphetamines ☐ Cocaine ☐ Designer/Club
Route: ☐ Smoke ☐ Inject ☐ Ingest ☐ Topical

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Last First MI mm/dd/yyyy

Sexual Activity: ☐ Not active ☐ Active Number of lifetime sexual partners: _____ ☐ Men ☐ Women ☐ Both
Do you have a caregiver? ☐ Yes ☐ No

Name: _____ Relationship: _____

Diet: ☐ Well Balanced ☐ Diabetic ☐ Vegetarian ☐ Fast food/Fats/Carbs
☐ Weight Loss Products _____ ☐ Vitamins/Herbs

Exercise/Activity Level: ☐ Sedentary ☐ Strength/Wt. Training ☐ Stretch/Balance
☐ Twenty minutes/day exercise ☐ Exercise three times weekly ☐ Aerobic/Cardiac

With whom do you live? ☐ Alone ☐ Children ☐ Spouse/Partner ☐ Parents ☐ Assisted Living: _____

Education: ☐ GED ☐ High School ☐ Did not complete High School ☐ College ☐ Advanced Degree ☐ Technical/Trade

Occupation: _____

Leisure activities: _____

Religion: _____

Do you: ☐ Use seatbelts ☐ Use a helmet ☐ Have guns in home ☐ Have smoke detector in home

Abuse

I feel safe at home: ☐ Yes ☐ No
Is there anyone you are afraid of? ☐ Yes ☐ No
Do you have a history of abuse? ☐ Yes ☐ No
Have you recently traveled to any foreign countries? ☐ Yes ☐ No List: _____

IMMUNIZATIONS	**mm/dd/year**
Tetanus/tDap	/ /
Influenza	/ /
Shingles	/ /
Meningitis	/ /
Hepatitis A	/ /
Hepatitis B	/ /
HPV	/ /
Prevnar 13	/ /
Pneumococcal	/ /

HEALTH MAINTENANCE	**mm/dd/year**
Mammogram	/ /
Bone Density/Dexa	/ /
Colonoscopy	/ /

PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION YOU WANT US TO KNOW ABOUT YOU

_____

_____

_____

_____

_____

_____

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Name: _____ DOB: _____
Last First MI mm/dd/yyyy

FAMILY HISTORY

What illnesses/conditions/diagnoses are in your family?

						Date:
Document the age of onset in the box for the appropriate disease and family member.						
	Mother	**Father**	**Sibling(s)**	**Child/Children**	**Other Relative**	**Other Relative**
Alcoholism/ Substance abuse						
Asthma						
Blood clots						
Breast cancer						
Colon cancer						
Prostate cancer						
Other cancer(s)						
Dementia						
Diabetes						
Heart disease						
High blood pressure						
High cholesterol						
Kidney disease						
Liver disease						
Lung disease						
Mental Health/ Psychiatric/Depression						
Stroke						
Thyroid condition(s)						
Other						

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Please check any symptoms you've experienced over the **LAST ONE TO TWO WEEKS:**

General/ Constitutional	☐ Appetite change ☐ Excessive sweating ☐ Fatigue	☐ Fever ☐ Chills ☐ Insomnia	☐ Night sweats ☐ Weight gain ☐ Weight loss	☐ None
Eyes	☐ Blurred vision ☐ Wear corrective lenses ☐ Double vision	☐ Dry eye ☐ Eye irritation ☐ Eye pain	☐ Spots in vision ☐ Vision loss	☐ None
Ear, Nose & Throat	☐ Ear pain ☐ Hearing loss ☐ Tinnitus/Ringing ☐ Vertigo (dizziness, balance problems) ☐ Facial pain	☐ Nasal drainage ☐ Nasal congestion ☐ Nose bleeds ☐ Postnasal drainage ☐ Bleeding gums	☐ Dental pain ☐ Mouth sores ☐ Hoarseness ☐ Sore throat	☐ None
Cardiovascular	☐ Exertional dyspnea (trouble breathing) ☐ Nocturnal dyspnea (trouble breathing)/cough	☐ Palpitations (irregular heartbeat) ☐ Decreased exercise tolerance	☐ Chest pain ☐ Exertional dyspnea	☐ None
Respiratory	☐ Cough ☐ Sputum production ☐ Coughing up blood	☐ Shortness of breath ☐ Pain with inspiration (deep breath) ☐ Wheeze	☐ Snoring	☐ None
Gastrointestinal	☐ Abdominal pain ☐ Bloating ☐ Food intolerance ☐ Nausea ☐ Vomiting	☐ Trouble swallowing ☐ Heartburn ☐ Change in bowel habits ☐ Constipation	☐ Diarrhea ☐ Black stools ☐ Bloody stools	☐ None
Genitourinary	☐ Change in urine stream ☐ Dysuria (painful urination) ☐ Hematuria (blood in urine) ☐ Incontinence	☐ Nocturia (overnight urination) ☐ Urinary frequency ☐ Urinary retention ☐ Menstrual changes/concerns	☐ Urinary urgency ☐ Sexual dysfunction ☐ Vaginal discharge	☐ None
Musculoskeletal	☐ Back pain ☐ Joint instability ☐ Joint pain ☐ Joint swelling	☐ Limited range of motion ☐ Leg pain at night ☐ Leg pain with exertion ☐ Neck pain	☐ Muscle aches ☐ Muscle cramps ☐ Muscle weakness ☐ Stiffness	☐ None
Integumentary/ Skin	☐ Hair changes ☐ Lesions/Change in moles ☐ Breast masses	☐ Pigment changes ☐ Rash ☐ Pruritis/Persistent itch	☐ Psoriasis	☐ None
Neurologic	☐ Abnormal gait/walking ☐ Focal weakness ☐ Headache(s) ☐ Confusion ☐ Memory problems	☐ Numbness ☐ Tingling ☐ Balance problems ☐ Restless legs ☐ Seizures	☐ Speech problems ☐ Twitches/Spasms ☐ Tremor ☐ Decreased sensation ☐ Other neurologic concern	☐ None
Psychiatric	☐ Anxiety ☐ Decreased concentration ☐ Irritability ☐ Suicidal thoughts	☐ Mood swings ☐ Panic attacks ☐ Insomnia ☐ Thought of hurting others	☐ Sadness/Tearfulness ☐ Depression ☐ Excessive sleep ☐ Hallucinations	☐ None
Endocrine	☐ Cold intolerance ☐ Heat intolerance	☐ Excessive thirst ☐ Excessive hunger	☐ Excessive urination	☐ None
Hematologic/ Lymph	☐ Bruising tendency ☐ Bleeding tendency	☐ Swollen glands ☐ Recurrent infections		☐ None
Allergy/ Immunologic	☐ Eczema ☐ Immunocompromised	☐ Hives/Urticaria ☐ Seasonal allergies		☐ None

Any other symptoms: _____

_____

_____ Patient or Guardian Name (please print)

_____ Patient or Guardian Signature

_____ Date

Senior Health First Patient Intake Supplement

Patient Name: _____ DOB: _____

Fall Assessment

1. Have you had a recent fall? ☐ Yes ☐ No
   If yes, how many times per year? _____
2. Do you have difficulty walking? ☐ Yes ☐ No
3. Do you use a walker, cane, or wheelchair? ☐ Yes ☐ No List Mobility Device: _____
4. Do you have a fear of a fall? ☐ Yes ☐ No
   (Note to provider - if any answer to fall question is YES, additional assessment is required)

Additional Patient Questions

We feel it is important in providing good, high quality medical care to you, that we understand how best to communicate with you and/or your family members. We believe it is important for you to understand as much as possible about your health issues and concerns. We reply on teaching as a tool to help you understand complex health issues. Please answer the following questions.

1. Are there any religious or cultural beliefs that we should be aware of that might impact how we present information to you. ☐ Yes ☐ No

Please Explain: _____

_____

_____

_____

2. In providing teaching to you about health concerns or issues are there particular ways that make it better for you to learn? (For example, I like to have written information to take home and study. Or I would like the nurse or provider explain it to me while I'm in the clinic for my appointment.

Please Explain: _____

_____

_____

_____

Signature: _____ Date: _____
(Patient or Authorized Representative)

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Senior Health First Patient Intake Supplement

Patient Name: _____ DOB: _____

Self Reported Functional Assessment

Please check below whether you can complete the task listed independently, or require some assistance from another person. If assistance is needed, please indicate if it is being provided.

	Can do* by myself	Can do with assistance	Cannot do at all
Eating	☐	☐	☐
Getting out of bed/chair	☐	☐	☐
Dressing	☐	☐	☐
Taking a bath or shower	☐	☐	☐
Using toilet	☐	☐	☐
Walking	☐	☐	☐
Prepare light meals	☐	☐	☐
Prepare full meals	☐	☐	☐
Light housekeeping	☐	☐	☐
Personal laundry	☐	☐	☐
Bill paying	☐	☐	☐
Using telephone	☐	☐	☐

Are there any additional questions you would like to have answered during your visit?

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____
(Patient or Authorized Representative)