New Patient Packet

Lifetime MEDICAL CENTER P.C.

PRIVIA MEDICAL GROUP

Patient Information:

Today's Date: _____

Last Name _____

First name _____

Middle Name _____

Sex _____

Date of Birth _____

SSN _____

Address _____

City & State _____

Zip _____

Home Phone _____

Mobile Phone _____

Email (required) _____

Race _____

Marital Status _____

Guardian (if applicable):

Last Name _____

First name _____

Primary Insurance:

Insurance Plan _____

ID # _____

Policy Holder: _____

Holder's DOB _____

Secondary Insurance:

Insurance Plan _____

ID # _____

Policy Holder: _____

Holder's DOB _____

Employment:

Employer _____

Employer _____

Emergency Contact:

Name _____

Relationship _____

Phone _____

Allergies:

_____

_____

_____

_____

_____

_____

Reaction:

_____

_____

_____

_____

_____

_____

Scanned by: _____

History entered by: _____

PT ID #_____

Appointment Date_____

MEDICATION POLICY

If you are on any of the following medication or on a pain contract or pain management from another physician, you must continue to receive your medication from that physician. Our office WILL NOT routinely prescribe these medications. We want to be upfront with you in regards to this so that we will be helping to eliminate any confusion. There may be other medication not listed below that may also be included in this policy:

BRAND NAME	GENERIC NAME
Xanex, Balium, Ativan	Alprozolam, Diazepam, Lorazepam
Anexsia, Bencap HC, Ceta-Plus, Co-Gesic, Dolact, Dolagesic, Dolorex Forte, Duocet, Hyphen, Hydrocet, Hydrogesic, Lorcet, Lorcet HD, Lorcet Plus, Lortab, Margesic-H, Norco, Panacet, Polygesic, Stagesic, T-Gesic, Ugesic, Vanacet, Vicodin, Cvicodin ES, Vicodin HP, Zydone	Hydrocodone
M-Oxy, OxyContin, OxyFast, OxyIR, Percolone, Roxicodone	Oxycodone
Endocet, Percocet, Roxicet, Roxilox, Tylox	Percocet
Mepergan	Mepergan
Astramorh PF, DepoDur, Duramorph, Infumorph, Kadian, Morphesian, MS Contin, MSIR, Oramorph, Poxanol, Roxanol 100	Morphine
Adipex (WEIGHT LOSS MEDICATION) Lonamin, Adipex-P	Phentermine Hydrochloride
Rela, Soma	Carisoprodol

Upon signing this acknowledgment of this policy, you are accepting this policy set forth by this office.

_____ _____

SIGNATURE PRINTED NAME

_____ _____

RELATIONSHIP TO PATIENT DATE

MEDICATIONS (REQUIRED)

List ***ALL*** medications you are taking, prescribed & over-the-counter.
Use the back if more space is needed or attach a medication list to this packet!

Medication	Strength	Frequency taken

PREFERRED PHARMACY: _____ **Phone:** _____

Patient Name: _____ Pt ID # _____

SOCIAL HISTORY

Exercise
- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ High level

Caffeine consumption
- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ Heavy

Alcohol
___Yes ___No

Tobacco / Vape
___Yes ___No

Drugs
Do you currently use recreational or street drugs?
___Yes ___No

MEDICAL HISTORY

Check all that apply

- ☐ Acid Reflux / GERD
- ☐ Anemia / Sickle Cell
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valves/ Stent
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding Problem
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Congenital Heart Lesion
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Emphysema / Bronchitis
- ☐ Epilepsy / Seizures
- ☐ Fainting / Dizzy Spells
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A,B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis/Penia
- ☐ Pacemaker
- ☐ Polio
- ☐ Psychiatric Disorder
- ☐ Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Disease ____
- ☐ Tuberculosis **SSS**

SURGICAL HISTORY

SURGERY	YEAR	HOSPITAL

FAMILY HEALTH HISTORY

Relation	Living	Age	Cancer	Depression	Diabetes	Heart Disease	Hypertension
Grandmother (maternal)	Y/N						
Grandfather (maternal)	Y/N						
Grandmother (paternal)	Y/N						
Grandfather (paternal)	Y/N						
Father	Y/N						
Mother	Y/N						
Brother/Sister	Y/N						
Brother/Sister	Y/N						

Patient Name: _____ Pt ID # _____