LAKESIDE MEDICINE

NEW PATIENT INTAKE FORM

Name _____

Date of Birth _____ SSN _____

Gender Male Female

Home Address _____

Cell _____ Home Phone _____Work phone _____

Email_____

Preferred contact method (circle): Texting Email Phone call

OK to leave voicemail message with test results? Yes No

Who can be contacted with your medical information: _____

Marital status (circle): Single Married Name of spouse: _____

Emergency contact _____ Relation to patient _____ Phone _____

Employer _____ Address _____

Primary Insured Person _____ self, spouse, other _____

Primary Insurance Company _____

Insurance Health plan. _____

Plan ID Number _____

Secondary insurance _____ Plan ID _____

Primary care provider _____

address _____

phone _____ fax _____

Referring Provider _____

address _____

phone _____ fax _____

Preferred local pharmacy _____

address _____

phone _____ fax _____

Mail order pharmacy _____

address _____

phone _____ fax _____

Date: _____ Signature: _____

Consent Form

LAKESIDE MEDICINE
1005 HWY 2, West
Sandpoint, ID 83864

Fax: 208-255-2066
Office: 208-290-3302

CONSENT TO TREAT

I am voluntarily seeking medical care and treatment from Lakeside Medicine and give permission to the medical staff of Lakeside Medicine to examine me, make diagnoses and provide treatment to me in accordance with the information, explanations and recommendations they provide me.

Patient Signature:_____ Date:_____

Legal Guardian/Relationship to Patient_____

CONSENT TO BILL

Payment is due at the time of service unless payment arrangements have been approved in advance by the practice manager. We accept credit cards, checks, cash and money orders. We are happy to process your insurance claim, and it is your responsibility to provide us with full and accurate information at the time of service.

I authorize Lakeside Medicine to bill my health insurance company for medical services provided.

I understand that my health insurance company may not cover all charges deemed medically necessary by Lakeside Medicine.

I understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

Private Pay accounts are expected to pay at the time of service. Pre-arrangements may be made with the practice manager prior to the appointment. Patients may be dismissed from the practice for failure to follow the financial agreement.

I authorize Lakeside Medicine to release my records to my health insurance company in accordance with privacy policy.

I am aware that Lakeside Medicine follows HIPPA privacy rules regarding my health information. I have been offered a copy of the policy to review.

Missed appointments without notice will be charged a $35.00 office fee.

Patient Signature:_____ Print Name_____

Legal Guardian/Relationship to Patient_____ Date_____

Review of Systems (√ Yes or No for symptoms in past 6 months, circle for symptoms TODAY)

Constitutional/Endocrine

☐ Yes ☐ No	Fever
☐ Yes ☐ No	Chills
☐ Yes ☐ No	Weakness/Fatigue
☐ Yes ☐ No	Weight Loss
☐ Yes ☐ No	Weight Gain
☐ Yes ☐ No	Insomnia
☐ Yes ☐ No	Snoring
☐ Yes ☐ No	Excessive thirst
☐ Yes ☐ No	Excessive urination
☐ Yes ☐ No	Cold or Heat intolerance

Other:_____

HEENT

☐ Yes ☐ No	Sore Throat
☐ Yes ☐ No	Stiff neck
☐ Yes ☐ No	Change in your voice
☐ Yes ☐ No	Sinus Drainage
☐ Yes ☐ No	Sinus Head Ache
☐ Yes ☐ No	Nose Bleeds
☐ Yes ☐ No	Ear ache/drainage
☐ Yes ☐ No	Hearing Loss
☐ Yes ☐ No	Ringing in your ears
☐ Yes ☐ No	Blurred Vision/Loss
☐ Yes ☐ No	Wear glasses or contacts
☐ Yes ☐ No	Itchy/watery eyes
☐ Yes ☐ No	Dental problems

Other:_____

Gastrointestinal

☐ Yes ☐ No	Nausea /Vomiting
☐ Yes ☐ No	Difficulty swallowing
☐ Yes ☐ No	Hemorrhoids
☐ Yes ☐ No	Diarrhea
☐ Yes ☐ No	Constipation
☐ Yes ☐ No	Bloody or Black Stools
☐ Yes ☐ No	Abdominal pain
☐ Yes ☐ No	Heart burn/indigestion
☐ Yes ☐ No	Frequent use of Laxatives

Other:_____

Urinary

☐ Yes ☐ No	Pain or burning with urination
☐ Yes ☐ No	Urinary frequency (Night or Day)
☐ Yes ☐ No	Blood in urine / Dark urine
☐ Yes ☐ No	Incontinence
☐ Yes ☐ No	Slow starting or stopping urine

Other:_____

Genital/Sex Organs

☐ Yes ☐ No	Penile discharge
☐ Yes ☐ No	Testicular lump/pain
☐ Yes ☐ No	Breast Pain/discharge/lump
☐ Yes ☐ No	Painful intercourse
☐ Yes ☐ No	Lack of sexual desire
☐ Yes ☐ No	Problems with performance

Other:_____

FEMALE Reproductive

☐ Yes ☐ No	Hot Flashes
☐ Yes ☐ No	Bleeding after menopause
☐ Yes ☐ No	Excessive menstrual bleeding
☐ Yes ☐ No	Unusual vaginal discharge

Age at onset of menstruation_____
1st day of last menstruation_____

☐ Yes ☐ No	Menstrual pain/cramps
☐ Yes ☐ No	Spotting between periods

Last pap smear:_____
Results:_____
Total Pregnancies:_____
Total live births:_____
Total miscarriages:_____
Total abortions:_____
Total C-sections:_____

Cardiac

☐ Yes ☐ No	Chest pain
☐ Yes ☐ No	Palpitation
☐ Yes ☐ No	Irregular heartbeat
☐ Yes ☐ No	Exercise intolerance
☐ Yes ☐ No	Leg swelling

Other:_____

Respiratory

☐ Yes ☐ No	Persistent Cough
☐ Yes ☐ No	Coughing up blood
☐ Yes ☐ No	Shortness of breath
☐ Yes ☐ No	Wheezing
☐ Yes ☐ No	Can't breathe laying flat

Other:_____

Skin

☐ Yes ☐ No	Rashes/Hives
☐ Yes ☐ No	Skin discoloration
☐ Yes ☐ No	Lesions/moles/warts
☐ Yes ☐ No	Ulcers
☐ Yes ☐ No	Itching
☐ Yes ☐ No	Nail Problems
☐ Yes ☐ No	Unusual Hair loss
☐ Yes ☐ No	Easy bruising

Other:_____

Psych

☐ Yes ☐ No	Depressed mood
☐ Yes ☐ No	Suicidal thoughts/plans
☐ Yes ☐ No	Agitation/irritability
☐ Yes ☐ No	Insomnia
☐ Yes ☐ No	Anxiety
☐ Yes ☐ No	Frequent crying spells

Other:_____

Musculoskeletal

☐ Yes ☐ No	Joint pains or stiffness
☐ Yes ☐ No	Joint swelling
☐ Yes ☐ No	Muscle weakness
☐ Yes ☐ No	Back pain
☐ Yes ☐ No	Muscle spasms/cramps
☐ Yes ☐ No	Falling

Other:_____

Neurologic

☐ Yes ☐ No	Frequent Headache
☐ Yes ☐ No	Seizures
☐ Yes ☐ No	Syncope (passing out)
☐ Yes ☐ No	Limb weakness
☐ Yes ☐ No	Limb numbness
☐ Yes ☐ No	Dizziness
☐ Yes ☐ No	Swallowing difficulty
☐ Yes ☐ No	Balance issues
☐ Yes ☐ No	Tremors
☐ Yes ☐ No	Rigidity

Other:_____
_____
_____

Past Medical History:

Head Aches	☐ Yes	☐ No	Date: _____
Stroke	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Pneumonia	☐ Yes	☐ No	_____
Diabetes (Type 1 or Type 2)	☐ Yes	☐ No	_____
Thyroid Disease (Low or High)	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____
Hearing Loss	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Blood Clots	☐ Yes	☐ No	_____
☐ Pulm Emboli (lung clots)	☐ Yes	☐ No	_____
☐ DVT (leg clots)	☐ Yes	☐ No	_____
Heart Burn, Reflux	☐ Yes	☐ No	_____
Stomach Ulcers	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
☐ Coronary Disease	☐ Yes	☐ No	_____
☐ MI/heart attacks	☐ Yes	☐ No	_____
☐ Congestive Heart Failure	☐ Yes	☐ No	_____
☐ Atrial Fibrillation	☐ Yes	☐ No	_____
☐ Angina	☐ Yes	☐ No	_____
☐ Valve Disorder	☐ Yes	☐ No	_____
High Cholesterol	☐ Yes	☐ No	_____
Gastrointestinal Bleeding	☐ Yes	☐ No	_____
Hepatitis (A, B, C)	☐ Yes	☐ No	_____
HIV / AIDS	☐ Yes	☐ No	_____
Chronic Wounds	☐ Yes	☐ No	_____
Cancer (type)	☐ Yes	☐ No	_____
Urinary Tract Infections	☐ Yes	☐ No	_____
Incontinence	☐ Yes	☐ No	_____
Kidney Stones	☐ Yes	☐ No	_____
COPD (Emphysema, Bronchitis)	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Bipolar Disorder	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Fibromyalgia	☐ Yes	☐ No	_____
Chronic Fatigue Syndrome	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Gout	☐ Yes	☐ No	_____
Osteoporosis	☐ Yes	☐ No	_____
Prostate Disease	☐ Yes	☐ No	_____
Breast Disease	☐ Yes	☐ No	_____
Erectile Dysfunction	☐ Yes	☐ No	_____

Other _____

Habits:

Alcohol: ☐ None ☐ Yes: How many drinks/day _____ frequency/week _____ What kind_____
Tobacco: ☐ None ☐ Yes: Chew or smoke?_____ How many/day _____ since_____
Caffeine: ☐ None ☐ Yes: What kind_____ How many/day _____
Other Recreational Drugs: ☐ None ☐ Yes: What kind_____ How many/day _____
Do you drive? ☐ Yes ☐ No Do you always wear a seatbelt? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No If yes, how much?_____

Social History:

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled
Current Occupation _____ Former Occupation _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner
Sexual preference: ☐ Men ☐ Women ☐ Both
Children (age):_____
Hobbies:_____
Sports:_____
Pets:_____
Other:_____

Past Surgical History (indicate date if known)

- ☐ None
- ☐ Cataracts_____
- ☐ LASIK_____
- ☐ Tonsillectomy_____
- ☐ Thyroidectomy_____
- ☐ Adenoidectomy_____
- ☐ Coronary Bypass_____
- ☐ Cardiac Stents_____
- ☐ Pacemaker_____
- ☐ Heart Valve_____
- ☐ Gall Bladder_____
- ☐ Appendectomy_____
- ☐ Bowel/Stomach Resection_____
- ☐ Hemorrhoidectomy_____
- ☐ Bariatric surgery_____
- ☐ Hysterectomy_____
- ☐ Endoscopy_____
- ☐ Colonoscopy_____
- ☐ Hernia_____
- ☐ Spinal Surgery_____
- ☐ Tubal Ligation_____
- ☐ Bladder surgery_____
- ☐ Prostate surgery/resection_____
- ☐ C-Section_____
- ☐ Orthopedic/joints_____
- ☐ Other_____

_____
_____
_____
_____

LAKESIDE MEDICINE & AESTHETICS, LLC
1005 Highway 2 West
Sandpoint, Idaho 83864
Phone: 208-290-3302 Fax: 208-255-2066

Health History Intake Form

Patient name: _____ Date:_____

Date of Birth: _____ Age: _____

Previous Primary Care Provider: _____

Address: _____

Phone:_____

Other Physicians involved in your care: _____

_____

Reason for visit today: _____

Allergies: (Medication/Food, indicate reaction): None: _____

_____

_____

Medication List: (Please list name/dose/frequency if known)

_____ _____

_____ _____

_____ _____

_____ _____

LAKESIDE MEDICINE, LLC
1005 Highway 2 West
Sandpoint, Idaho 83864
K. Fuhrman BC -ARNP
Fax: 208-255-2066
Phone: 208-290-3302

HIPPA Privacy Authorization Form & Release of Information Form

****Authorization for Use or Disclosure of Protected Health Information****
*** (The Health Insurance Portability & Accountability Act, 45 C.F. R. Parts 160 & 164) ***

1) Authorization: I Authorize: Previous Care Records from:
   1. _____
   2. _____
   3. _____

(Health Care Provider to use and disclose the protected health information described below) to be sent to Lakeside Medicine, LLC and or Kelly Fuhrman, Board Certified Advanced Registered Nurse Practitioner. (Individual seeking the information.)

2) Effective time Period:
   _____This Authorization for Release of Information covers the period of Healthcare Date:_____ to _____.

   *****OR******
   _____ All PAST, PRESENT AND FUTURE PERIODS OF TIME

3) Extent of Authorization:
   _____ I authorize the Release of Information for MY COMPLETE HEATLH CARE RECORD (including records relating to Mental Illness, communicable disease, HIV, or AIDS, and treatment of Drugs and or Alcohol Abuse)

   *******OR*******
   _____ I authorize the Release of my Complete Health Care Record with the EXCEPTION of the following information:

   _____ Mental Health Records _____Communicable Disease (HIV & AIDS)
   _____ Alcohol/ Drug Abuse Treatment

4) I understand that I have the right to REVOKE this authorization, in writing, at any time.

5) Send copies: EKG, CXR, Imaging, Surgeries, Consults, last office visit, labs

Signature of Patient: _____ Date: _____

PRINT NAME of patient or Personal representative: _____ DOB_____