LAKESIDE
MEDICINE & AESTHETICS

NEW PATIENT INTAKE FORM
2025

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: _____ Page 1 of 1 Signature: _____

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 <u>always</u> 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_____
- _____

_____

_____

_____

_____

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 _____

LAKESIDE MEDICINE & AESTHETICS 200 Main Street Suite 210 Sandpoint, ID 83864

Phone: 208-290-3302 HEALTH HISTORY Fax: 208-255-7879

Patient Name: _____ DOB: _____

Age: _____ Todays Date: _____ Primary Care Provider: _____

Health care team: _____

Reason for visit today: _____

Allergies to medications: _____

_____

PHARMACY: _____

Medication List: -and Supplements, over the counter: name, dose, frequency of medication

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Height: _____ Weight: _____ Goal Weight: _____

Family hx: alive or deceased: Cancer, HTN, Cholesterol, Demenita, Heart Attack, Stroke, DBM2

Mom - _____

Dad _____

Siblings _____

Brother: _____

Sister: _____

Grandparents- Maternal and Fraternal

_____

Consent Form

Kelly Fuhrman, ARNP-BC
Lakeside Medicine & Aesthetics
200 Main Street
Suite 210
Sandpoint, Idaho 83864

Fax: 208-255-7879
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_____

KELLY FUHRMAN-BOARD CERTIFIED, ARNP **LAKESIDE MEDICINE & AESTHETICS**

200 Main, Suite: 210 SANDPOINT, IDAHO 83864 208-290-3302, FAX 208-255-7879

Date: _____

HIPPA Privacy Authorization form & Release of Information Form

The Health Insurance Portability & Accountablity Act: 45 CFR Parts 160 & 164

I AUTHORIZE PREVIOUS HEALTH CARE RECORDS FROM:

1)_____

2)_____

3)_____

4)_____

Effective date and time period: This Authroization for Release of Information:

_____ **All past, present, and future periods of time**

Extent of Authorization:

_____ **Release my complete health care record**

DO NOT release Mental Illness, HIV, AIDS, Drug & Alcohol treatmet: _____

I may revoke this authorization, in writing, at any time: _____

5) Send copies of: last chart note, EKG, ECHO, CT scan, MRI scan, CXR, Surgery Procedure, LAB

Signature of Patient: _____ DOB_____

PRINT NAME of patient or peronal representative:_____ Date_____

LAKESIDE MEDICINE, LLC
K. Fuhrman BC -ARNP

200 MAIN ST. SUITE 210
SANDPOINT, ID 83864

208-290-3302 OFFICE
208-255-7879 FAX

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_____