PRISM HEALTH

Prism Health recognizes all genders and identities; however, most insurance companies and legal entities unfortunately do not. Please be aware that the legal name and sex you have listed on your insurance must be used on documents pertaining to insurance and billing. When addressing you, we will use the name and pronouns that you request to assure that we are using the most respectful language. Please let us know if there's anything we can do to make your time with us more comfortable.

PATIENT REGISTRATION **DATE:**	
Legal Last Name: Legal First: Middle:	Date of Birth:
Name You Go By: Social Security Number:	Sex Assigned at Birth: ☐Male ☐Female ☐Intersex
Pronouns You Use: ☐He/His ☐She/Hers ☐They/Theirs ☐Another_____	
Gender Identity: ☐Male ☐Female ☐Trans Male ☐Trans Female ☐Two-Spirit ☐Gender Non-Conforming ☐Non-Binary ☐Decline ☐Another_____	
Sexual Orientation: ☐ Gay ☐ Lesbian ☐ Straight ☐ Bisexual ☐ Queer ☐ Pansexual ☐ Don't know ☐ Choose not to say ☐ Another _____	
Race: ☐ Hispanic ☐ Non-Hispanic ☐ Choose not to say ☐ Don't know Ethnicity: ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Pacific Islander ☐ Choose not to say ☐ Don't know	
Physical Address: City: State: Zip:	Main Phone: OK to leave voicemail? ☐Y ☐N OK to text? ☐Y ☐N
Mailing Address(if different): City: State: Zip:	Other Phone: OK to leave voicemail? ☐Y ☐N
Employer: Occupation: Full-time ☐ Part-time ☐	Work Phone: OK to leave voicemail? ☐Y ☐N
Email address for patient web portal, MyChart (must be 18 years or older):	
Preferred Written / Spoken Language: ☐English ☐Spanish ☐Mandarin ☐Russian ☐ASL ☐Another_____	Do you need interpretation services? ☐N ☐Y, language:_____ Do you have a visual impairment? ☐Y ☐N
Are you a US Veteran? ☐Y ☐N	

EMERGENCY CONTACT
Emergency Contact Name: _____ Relationship: _____ Phone: _____

INSURANCE AND INCOME INFORMATION		
Insurance Name:	Policy/Subscriber Number:	Group Number:
Name of Guarantor: ☐patient	Guarantor Date of Birth:	Guarantor Address: ☐same as patient
Name of Subscriber: ☐patient	Subscriber Date of Birth:	Subscriber Address: ☐same as patient

PRISM HEALTH

Patient Name: _____ DOB: _____

Name You Use: _____

PREVIOUS PROVIDER INFORMATION

Are you transferring your care from another healthcare provider? ☐Y ☐N

If so, please list the name and phone number of your previous provider.
We will also ask you to fill out a Release of Information so we can obtain your medical records.
Name of Provider: _____
Phone Number: _____

MEDICAL HISTORY

Please check ALL that apply:

☐Alcohol Abuse	☐Chronic Pain	☐Heart Disease	☐Seizures
☐Asthma	☐Depression	☐Hepatitis	☐Sleep Apnea/Snoring
☐Anemia	☐Dental Issues	☐High Blood Pressure	☐Strokes/TIA
☐Arthritis	☐Diabetes	☐High Cholesterol	☐STD/STI
☐Blood Clots	☐Dialysis	☐HIV/AIDS	☐TB
☐Cancer	☐Drug Addiction	☐Insomnia	☐Tobacco Abuse
☐COPD	☐Headaches	☐Mental Health Issues	☐Ulcers

REVIEW OF SYSTEMS

Please check ALL that apply and have occurred within the last three months, and lasting several days:

BLOOD	☐Anemia	☐Clots	☐Fatigue	☐Bleeding Issues
CARDIOVASCULAR	☐Chest Pain	☐Feet/Leg Swelling	☐Fainting	☐Palpitations
GASTROINTESTINAL	☐Nausea/Vomiting	☐Constipation	☐Diarrhea	☐Heartburn
GLANDS/HORMONES	☐Cold Intolerance	☐Heat Intolerance	☐Menopause	☐Menstrual Issues
MENTAL HEALTH	☐Anxiety	☐Depression	☐Hallucinations	☐Suicidal Ideations
MUSCULOSKELETAL	☐Pain	☐Stiffness	☐Swelling	☐Weakness
NEUROLOGICAL	☐Weakness	☐Headaches	☐Neck/Back Pain	☐Limb Numbness
OB/GYNECOLOGICAL	☐Burning	☐Cramps	☐Pregnancy	☐Itching
RENAL	☐Kidney Stones	☐Urgency/Pain	☐Blood in Urine	☐Incontinence
RESPIRATORY	☐Cough	☐Shortness of Breath	☐Wheezing	☐ Wet cough
SKIN	☐Bruising	☐Burns	☐Itching/Rash	☐Wounds

MEDICATIONS

List all of your current medications and dosage. Include over-the-counter, vitamins, supplements, CPAP machines, allergy medications, and anything else you take:

Medication Name	Dose	Frequency

PRISM HEALTH

Patient Name: _____ DOB: _____

Name You Use: _____

ALLERGIES List all medication, and other allergies (food, latex, etc.) you have as well as the reaction (hives, rash, swelling, etc.):	
Allergy	Reaction

FAMILY HISTORY Please list any illnesses, diseases, and/or conditions that any of your immediate family members has had:	
Family Member	Illness / Disease / Condition

SURGICAL HISTORY List all surgeries you have had and the date of the surgery:	
Surgery	Date

SOCIAL HISTORY	
How many caffeinated beverages do you have per day? _____	What caffeinated beverages do you drink? ☐Coffee ☐Tea ☐Soda ☐Energy Drinks ☐Other _____
Do you smoke tobacco products? ☐Y ☐N What do you smoke? _____ How many packs per day? _____ Start date: _____ Quit date: _____	Do you chew tobacco? ☐Y ☐N Start date: _____ Quit date: _____ Would you like to discuss quitting tobacco products? _____
Do you drink alcohol? ☐Y ☐N What do you drink? ☐ Beer ☐ Wine ☐ Liquor	How many drinks per week? _____
Do you feel unsafe in your current home? ☐Y ☐N	Have you been a victim of physical or sexual assault? ☐Y ☐N

PRISM HEALTH

Patient Name: _____ DOB: _____

Name You Use: _____

SOCIAL HISTORY CONTINUED				
Over the last two weeks, how often have you been bothered by any of the following issues:				
Little interest or pleasure in doing things	☐Not at all	☐Several days	☐Almost every day	☐Every day
Feeling down, hopeless, depressed	☐Not at all	☐Several days	☐Almost every day	☐Every day
Trouble falling/staying asleep, sleeping too much	☐Not at all	☐Several days	☐Almost every day	☐Every day
Feeling tired or having little energy	☐Not at all	☐Several days	☐Almost every day	☐Every day
Poor appetite or overeating	☐Not at all	☐Several days	☐Almost every day	☐Every day
Feeling badly about yourself	☐Not at all	☐Several days	☐Almost every day	☐Every day
Trouble concentrating at work or school	☐Not at all	☐Several days	☐Almost every day	☐Every day
Moving/speaking slowly, or being fidgety/restless	☐Not at all	☐Several days	☐Almost every day	☐Every day
Thoughts of suicide, or hurting yourself	☐Not at all	☐Several days	☐Almost every day	☐Every day

SEXUAL HISTORY	
Are you currently sexually active? ☐Y ☐N	If no, have you been sexually active in the past? ☐Y ☐N
Are your sex partners (check all that apply): ☐A person with a penis ☐A person with a vagina	What body parts do you use when you have sex? ☐Penis ☐ Vagina ☐Anus ☐Mouth
Has there been any change to your sexual desire? ☐Y ☐N	If yes, please describe the change
Do you have any risk factors for HIV? (STIs, HIV+ partner, needle use, blood transfusion, etc.) ☐Y ☐N	What method(s) of birth control do you use? ☐Condom ☐Spermicide ☐Dental Dam ☐ IUD ☐NuvaRing ☐Depo ☐Patch ☐Withdrawal ☐None ☐Another _____
Have you ever had an STD/STI? ☐Y ☐N	If yes, please check all that apply: ☐Gonorrhea ☐Chlamydia ☐Herpes ☐Syphilis ☐HPV ☐HIV ☐Another _____
Have you ever been tested for HIV? ☐Y ☐N	Would you like to be tested for HIV? ☐Y ☐N
Are you trying to become pregnant? ☐Y ☐N ☐N/A	Do you have pain during intercourse? ☐Y ☐N ☐Sometimes
Do you have any questions or concerns about your sexual health?	

OTHER

Is there anything else you would like your medical provider to know about you?

Turn page over to sign →

PRISM HEALTH

I certify that the information I have given on my patient intake forms is correct and complete to the best of my knowledge. I acknowledge that keeping any health information from my provider may hinder them from being able to give me adequate patient care. It is my responsibility to keep my provider informed of any new health issues that may arise.

_____ _____

Patient Signature Date

FOR OFFICE USE ONLY

☐Verified and Completed:_____ ☐Scanned:_____ ☐Documented: _____