IKON | Health

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www.IkonHealthMD.com

New Patient Medical History and Intake Form

PATIENT DEMOGRAPHICS

Name: ____ Date of Birth:___________________

Gender: Male ☐ Female ☐ Height: _____________ Weight: _______________________

Address
Street: ____

City: ________________________________ State: ______________ Zip Code: ________________

Home Phone: ___________________________ Cell Phone:_________________________________

Email: ____

Primary Contacts:

1. Name: ___________________________ Phone:____________________________

   Relationship: ______________________ Email:_____________________________

2. Name: ___________________________ Phone:____________________________

   Relationship: ______________________ Email:_____________________________

3. Name: ___________________________ Phone:____________________________

   Relationship: ______________________ Email:_____________________________

Medical Power of Attorney (if applicable):

Name: ___________________________ Phone:____________________________

Relationship: ______________________ Email:_____________________________

Current/ Former
Primary Care Physician:____

Phone: _________________________________

Specialist:____________________________________

Phone: _______________________________________

INSURANCE INFORMATION

Medicare Insurance Number: ______________________________

Secondary Insurance Name: _______________________________

Subscriber ID: _______________________ Group Number: _____________________

Primary Card Holder: Self ☐ Spouse ☐ Other: ________________________

Name of Policy Holder: ____________________________________

Date of Birth of Policy Holder: ______________________________

MEDICAL HISTORY

Current Medical Conditions: *Please list below.* N/A ☐

____

____

____

Surgical History: *Please list below.* N/A ☐

Procedure	Date

Allergies: *Please list below.* N/A ☐

____

____

Medications: *Please list all medications/supplements you are taking*:

Medication/Supplement	Dosage	Frequency

Preferred Pharmacy Name:___________________________Phone:_________________________

Address:____

Smoking History: None ☐ Former Smoker ☐ Current Smoker ☐

Drinking History: Drinks per week ________

Drug Use: Never ☐ Former Use ☐ Current Use ☐

How did you hear about us?

Please select an option below.

☐ Website/ Google Search

☐ Advertisement (e.g., The Beacon)

☐ Recommended by a friend/ family

☐ Another provider (please provide their name): ___________________________________

☐ Other (please specify) ____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Ikon Health, LLC to release any information including the diagnosis and the records of any examination rendered to me during the period of such care to Medicare and/or my insurance provider. I voluntarily consent to this evaluation and understand that I am solely responsible for payment for services.

Patient's Signature: ____________________________________ Date: _________________