NAME_____ DOB _____ MR#_____

PATIENT INTAKE FORM

Vaccination Status

Are you current on the following vaccines?

Influenza (flu shot this season): ☐ Yes ☐ No
If you answered **No**, please indicate the reason:
☐ Allergy/contraindication ☐ Personal choice/refusal ☐ Not offered/unaware

☐ Other: _____

Tobacco & Nicotine Use

Do you currently use any tobacco or nicotine products (such as cigarettes, cigars, chewing tobacco, or e-cigarettes/vaping)

☐ Yes ☐ No ☐ Former user (quit date: _____)

Advance Directive/Living Will (to be answered by all patients 65 and older)

Do you have an Advance Directive or Living Will?

☐ Yes ☐ No ☐ Unsure

Healthcare Power of Attorney (POA)

Your Healthcare Power of Attorney (also known as your surrogate or medical decision maker) is the person authorized to make healthcare decisions on your behalf if you are unable to do so.

Have you designated a Healthcare Power of Attorney?
☐ Yes ☐ No ☐ Unsure

Name of POA: _____

Relationship to Patient: _____

Phone Number: _____

Signature: _____ **Date:** _____ / _____ / _____
(MM/DD/YYYY)