*NAME:*_____ *DOB:*_____ *MR#:*_____

PATIENT INTAKE FORM

Due to new federal government and all insurance company guidelines, we are required to have this questionnaire filled out by all new and established patients once per year. We appreciate your full cooperation and patience in filling this out.

VACCINATIONS:

For all patients ages 6 months and older, have you had a recent Flu Vaccine?

_____Y (Influenza Immunization previously received during influenza season) or
_____N (Influenza Immunization ordered or recommended, but not performed) or
_____ Y (Allergic to Influenza Immunization and cannot get one)

For all patients 65 & older, have you received the Pneumonia Vaccine within the last 5 years?

_____Y (Previously received) or _____N (Not received or administered)
_____Y (Allergic to Pneumonia Immunization and cannot get one)

ADVANCE CARE PLAN for ALL PATIENTS 65 AND OLDER:

Do you have the following and please mark which applies:

Living Will (Advance Care Plan) _____Y _____N

Power of Attorney (Surrogate & Medical Decision Maker/Beneficiary) _____Y _____N

Name of Power of Attorney/Beneficiary:_____
Relationship to You:_____**Phone:**_____

TOBACCO USE for ALL PATIENTS 18 YEARS AND OLDER:

Please choose the following that best describes your tobacco use:

_____Never _____Current Smoker _____Former Smoker

SIGNATURE:_____ ***DATE:***_____