

PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of 4 Points Primary Care. This form is used to collect information about new patients and used for internal purposes only. The information you supply is confidential and will be treated accordingly.

PATIENT DETAILS

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____

Social Security Number: _____ E-Mail: _____

Ethnicity/Race: _____ Weight: _____ Height: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse Name: _____ Spouse Phone: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ E-Mail: _____

Home Phone: _____ Mobile Phone: _____

PRIMARY INSURANCE POLICY

Primary Insurance Company: _____

Group #: _____ ID #: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are **not** the policyholder for your primary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ Date of Birth: _____

Policyholder Social Security Number: _____

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: _____

Group #: _____ ID #: _____

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____

Complete the following if you are **not** the policyholder for your secondary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ Date of Birth: _____

Policyholder Social Security Number: _____

TREATING PHYSICIANS

Primary Care Physician: _____ Phone: _____

List all other active treating physicians:

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

4 POINTS PRIMARY CARE
207 DUNSON ST.
ANDALUSIA, AL. 36420

PHONE: 334-833-1150
FAX: 334-746-5884

PATIENT NAME: _____
DATE OF BIRTH: _____ PHONE: _____
ADDRESS: _____

I hereby authorize the release of my medical records:

() From: 4 Points Primary Care () To: 4 Points Primary Care

Name of Facility or Provider: _____
Address: _____
Phone: _____ Fax: _____

Information To Be Released (Check all that apply)

() Complete Medical Record () Office Notes () Lab Results () Imaging Reports
() Billing Records () Immunization Records
() Other: _____

Date (s) of Service to be Released: _____

Purpose of Disclosure (Check One)

() Continuing Medical Care () Insurance () Personal Use () Legal
() Other: _____

Acknowledgment & Authorization

I understand that:

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization at any time in writing, except where action has already been taken.
- Information disclosed may be subject to re-disclosure and may no longer be protected under federal privacy regulations.
- Unless otherwise revoked, this authorization will expire one (1) year from the date of signature below.

Patient Signature: _____ Date: _____

If Signed by Personal Representative:

Name: _____

Relationship to Patient: _____

Witness Signature: _____

ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____

MEDICATION

List the medications you are currently taking including the dosage:

Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____

FAMILY HISTORY

List any major conditions/illnesses that your immediate family members have had:

Relative	Condition	Living?	If deceased, at what age?
Mother		☐ Y ☐ N	
Father		☐ Y ☐ N	
Sibling		☐ Y ☐ N	
Other:		☐ Y ☐ N	
Other:		☐ Y ☐ N	

SURGICAL HISTORY

List any surgeries, fractures, major illnesses, or hospitalizations that you have had:

Description	Doctor	Location	Year

MEDICAL HISTORY

Have you ever had any of the following?

Anemia	☐ Y ☐ N	Hypertension	☐ Y ☐ N
Arthritis Conditions	☐ Y ☐ N	Male Hypogonadism	☐ Y ☐ N
Asthma	☐ Y ☐ N	Hypothyroidism	☐ Y ☐ N
Atrial Fibrillation	☐ Y ☐ N	Infection Problems	☐ Y ☐ N
Bleeding Problems	☐ Y ☐ N	Insomnia	☐ Y ☐ N
Benign Prostatic Hyperplasia	☐ Y ☐ N	Irritable Bowel Syndrome	☐ Y ☐ N
Coronary Artery Disease	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N
Cancer	☐ Y ☐ N	Menopause	☐ Y ☐ N
Cardiac Arrest	☐ Y ☐ N	Migraines/Headaches	☐ Y ☐ N
Celiac Disease	☐ Y ☐ N	Neuropathy	☐ Y ☐ N
Chest Pain	☐ Y ☐ N	Onychomycosis	☐ Y ☐ N
Congestive Heart Failure	☐ Y ☐ N	Organ Injury	☐ Y ☐ N
Chronic Fatigue Syndrome	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N
Depression	☐ Y ☐ N	Pulmonary Embolism	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Seizure Disorders	☐ Y ☐ N
Drug/Alcohol Abuse	☐ Y ☐ N	Shortness of Breath	☐ Y ☐ N
Erectile Dysfunction	☐ Y ☐ N	Sinus Conditions	☐ Y ☐ N
Fibromyalgia	☐ Y ☐ N	Stroke	☐ Y ☐ N
Gerd	☐ Y ☐ N	Syndrome X	☐ Y ☐ N
Heart Disease	☐ Y ☐ N	Tremors	☐ Y ☐ N
Hyperinsulinemia	☐ Y ☐ N	Wheat Allergy	☐ Y ☐ N
Hyperlipidemia	☐ Y ☐ N		

List any other medical problems that you have had:

HEALTH CONCERNS

What's your primary health concern? _____

Approximately when did this issue begin? _____

Does the issue cause you pain? ☐ Yes ☐ No

- If so, where? _____

How has the pain changed since it began? ☐ Increased ☐ Decreased ☐ Unchanged

How quickly did you current pain begin? ☐ Gradually ☐ Suddenly

How often does your pain occur? ☐ Constantly ☐ Occasionally ☐ Rarely

When is your pain at its worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

What are your current symptoms? _____

Check any of the following that describe your pain:

Aching	☐	Numbness	☐	Spasming	☐	Throbbing	☐
Cramping	☐	Shock-like	☐	Squeezing	☐	Tingling	☐
Dull	☐	Shooting	☐	Stabbing/Sharp	☐	Tiring/Exhausting	☐
Hot/Burning	☐						

List any other health concerns that you would like us to know about:

SOCIAL HISTORY

Do you currently consume alcohol? ☐ Yes ☐ No

- How many drinks per week? _____

Do you currently smoke? ☐ Yes ☐ No

- What do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____
- How many cigarettes do you smoke per day? _____

Do you currently use any other drugs? ☐ Yes ☐ No

- What other drugs do you take? _____
- How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Do you drink caffeine? ☐ Yes ☐ No

- How many cups per day? _____

How frequently do you exercise? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Are you on a special diet? ☐ Yes ☐ No

- What diet? _____

Complete the following if applicable:

Are you planning a pregnancy? ☐ Yes ☐ No

Are you pregnant now? ☐ Yes ☐ No

What type of contraception do you currently use? _____

When was your last menstrual cycle? _____

When was your last mammogram? _____

When was your last colonoscopy? _____

ADVANCE DIRECTIVES

Living will? _____

Healthcare Proxy? _____

DNR? _____

None at this time? _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone:** _____

Street Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

FINANCIAL POLICY ACKNOWLEDGEMENT

Copays, deductibles, and balances are due at time of service.
Insurance is billed as a courtesy; coverage is not guaranteed.
Any balance not paid by insurance is the patients responsibility.
Accounts unpaid after 90 days may be sent to collections in accordance with Alabama law.

Patient initials: _____ **Date:** _____



4POINTS PRIMARY CARE

207 DUNSON STREET, ANDALUSIA, AL 36420

www.4pointsprimarycare.com

PHONE: (334) 833 -1150 FAX: (334) 746 - 5884

\$50 NO-SHOW POLICY

At 4 Points Primary Care, we value our patients' time and the time of our healthcare team. Because appointment times are reserved specifically for each patient, we require at least **24 hours' notice** when cancelling or rescheduling an appointment.

- A **\$50 no-show fee** will be charged when:
- A patient does not attend a scheduled appointment.
- The **\$50 fee is not an insurance covered service and is patient's responsibility**. Payment of the fee is required before another appointment is scheduled.
- We understand that emergencies and unexpected circumstances can occur. No-show fees may be waived at the discretion of 4 Points Primary Care when circumstances warrant.
- Repeated missed appointments may result in additional restrictions on future scheduling or dismissal from the practice, consistent with applicable practice policies and laws.
- I have read and understand the 4 Points Primary Care appointment cancellation and No-Show Policy and understand that I may be responsible for a **\$50 fee** for missed appointment.

Date of Birth: _____

Patient Name: _____

Signature: _____

HIPAA Privacy Acknowledgement

I acknowledge receipt of the Notice of Privacy Practices from 4 Points Primary Care and understand my rights under HIPPA and Alabama law.

Patient signature: _____ Date: _____

COMMUNICATION, CANCELLATION AND NO-SHOW POLICY

We would appreciate a 24 hour notice if you need to cancel your appointment. Repeated no-shows may result in a no-show fee.

Patient signature: _____ Date: _____

COMMUNICATION AND ELECTRONIC CONSENT

I consent to receive appointment reminders, test results, and billing communications via phone, text, email, or patient portal.

Patient initials: _____ Date: _____

CONSENT FOR TREATMENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

- a) **Accurate Information.** I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
- b) **Patient Rights and Responsibilities.** I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.
- c) **Release of Medical Information.** I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
- d) **Consent for Treatment.** I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

- e) **Consent to Communication.** I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.
- f) **Acknowledgment.** By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ **Date:** _____

Print Name: _____



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CONTROLLED SUBSTANCE / OPIOID MEDICATION AGREEMENT

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ MRN: _____

Prescribing Physician/Provider: _____

Medication(s): _____

Designated Pharmacy: _____

Pharmacy Phone: _____

1. Purpose

This agreement establishes expectations for the safe and appropriate use of controlled medications, including opioid medications, prescribed by this practice. The purpose is to support safe treatment, reduce medication-related risks, and promote communication between the patient and healthcare team.

2. Patient Responsibilities

I agree to:

- Take my medication **only as prescribed** and not increase, decrease, or change the medication without first discussing it with my prescribing clinician.
- Obtain controlled-substance prescriptions primarily from this prescribing clinician/practice unless another healthcare provider is treating me with the knowledge of my prescribing clinician.
- Use one pharmacy whenever reasonably possible and notify the office if my pharmacy changes.

- Never share, sell, trade, or give my medication to another person.
- Store my medication securely and take reasonable precautions to prevent theft, loss, or unauthorized use.
- Not take medication more frequently or in greater amounts than prescribed.
- Tell my healthcare providers about all prescription medications, over-the-counter medications, supplements, and other substances I use.
- Inform other healthcare providers that I am receiving controlled-substance treatment when relevant to my care.
- Avoid alcohol and other substances that may cause excessive sedation or breathing problems while taking opioid medication, unless specifically discussed with my healthcare provider.
- Not drive or operate dangerous machinery if I am impaired, excessively sleepy, dizzy, or otherwise affected by my medication.
- Keep scheduled appointments and participate in clinically appropriate monitoring.

3. Prescriptions and Refills

I understand that:

- Controlled-substance prescriptions are provided based on my clinician's medical judgment and applicable laws and regulations.
- Refills should be requested during regular office hours and before my medication runs out.
- Early refills are generally not provided because medication was lost, stolen, misplaced, or taken more frequently than prescribed. Exceptions, if any, are determined by the prescribing clinician and applicable requirements.
- An office visit or other clinical evaluation may be required before a prescription is renewed.
- The medication, dosage, or treatment plan may be changed when medically appropriate.

4. Monitoring

I understand that safe controlled-substance treatment may include:

- Review of the state Prescription Drug Monitoring Program (PDMP).
- Urine, blood, saliva, or other drug testing when clinically appropriate.
- Medication or pill counts.
- Medication reconciliation.
- Assessment of treatment effectiveness, side effects, function, and safety.

I understand that unexpected monitoring results may require additional evaluation and may affect my treatment plan.

Patient Initials: _____

CONTROLLED SUBSTANCE / OPIOID MEDICATION AGREEMENT

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5. Other Medications and Substances

I agree to inform my prescribing clinician before taking or receiving other controlled substances or medications that may cause sedation, including opioids, benzodiazepines, sleep medications, muscle relaxants, or other central nervous system depressants.

I understand that combining opioids with alcohol, certain medications, or other sedating substances can increase the risk of excessive sedation, respiratory depression, overdose, and death.

Patient Initials: _____

6. Lost or Stolen Medication

I understand that I am responsible for safeguarding my medication. I will promptly notify the prescribing office if medication is lost or stolen.

Replacement of lost or stolen controlled medication is **not guaranteed** and will be handled according to the clinician's judgment, office policy, and applicable law.

Patient Initials: _____

7. Treatment Changes or Discontinuation

I understand that signing this agreement does not guarantee that I will receive a particular medication, dosage, or quantity.

My clinician may change, reduce, taper, or discontinue controlled-substance treatment when medically appropriate, including when treatment risks outweigh benefits, treatment goals are not being met, significant adverse effects occur, or safety concerns arise.

Whenever clinically appropriate, treatment changes and alternative treatment options will be discussed with me.

Patient Initials: _____

8. Emergency and Outside Medical Care

I agree to inform emergency departments, urgent-care providers, surgeons, dentists, and other healthcare professionals about my current controlled-substance treatment when

relevant.

I understand that emergency medical treatment may be provided by other healthcare professionals when necessary.

Patient Initials: _____

9. Patient Acknowledgment

By signing below, I acknowledge that:

- I have read this agreement or had it explained to me.
- I have had an opportunity to ask questions.
- I understand the responsibilities and risks associated with controlled-substance treatment.
- I agree to follow my prescribed treatment plan and applicable practice policies.
- I understand that this agreement does not replace my clinician's medical judgment or applicable federal and state laws and regulations.

SIGNATURES

Patient Signature: _____

Date: _____

Printed Patient Name: _____

Prescribing Physician/Provider Signature: _____

Date: _____

Printed Name/Credentials: _____

Witness/Staff Signature (if applicable): _____

Date: _____

OFFICE USE ONLY

Medication / Strength / Directions:

Next Follow-Up Date: _____

Additional Practice-Specific Requirements:

Practice/Clinic Stamp:
