Symbios Health

Please return completed form by email or fax:
Email: info@mysymbios.com
Fax: 843-738-4301

Date:_____

Patient Information

Patient Name (Last)_____ (First)_____ (MI)_____

Preferred Name:_____ Date of Birth_____ Social Security Number_____

Sex_____ Marital Status:_____ Patient Email:_____

Address_____City_____ State_____Zip_____

Home Phone _____Cell Phone _____Work Phone_____

Race (Check One)
African American/Black
American Indian
Alaska Native
Asian Native Hawaiian/Pacific Islander
White
Other

Ethnicity (Circle One)
Hispanic or Latino
Not Hispanic or Latino

Occupation:_____ Employer:_____

Emergency Contact Full Name:_____ Phone:_____

Primary
Insurance:_____Policy#_____

Group:_____ Subscriber: _____ DOB:_____

Secondary Insurance:_____Policy#_____

Group:_____ Subscriber: _____ DOB:_____

PATIENT COMMUNICATION PREFERENCES

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers. You will be asked several questions that fall into HIPAA, please answer them to help us protect your privacy.

Do you authorize this office to mail correspondence to the address you have on file? YES☐ NO☐

Do you authorize this office to leave voice mail messages (Home answering machine/Cell phone) regarding your medical conditions, test results, medications, and appointments? YES☐ NO☐

Do you authorize this office to send text/SMS messages regarding your medical conditions, test results, medications, and appointments? YES☐ NO☐

Do you authorize this office to send emails regarding your medical conditions, test results, medications, and appointments? YES☐ NO☐

Do you want to use the immunization registry? YES☐ NO☐

Do you want to participate in immunization info sharing? YES☐ NO☐

Do you want to participate in health info exchange? YES☐ NO☐

Tobacco:

Do you currently use tobacco ? ☐Yes ☐No

Did you use tobacco in the past ? ☐Yes ☐No

How long: _____

☐Cigarettes ___/day ☐Chew ___/day ☐Cigars ___/day

Alcohol Intake:
☐None ☐Occasional ☐Moderate ☐Heavy

Caffeine:
☐None ☐Occasional ☐Moderate ☐Heavy
cups/cans per day ?_____

Drugs:
Do you currently use recreation or street drugs ? ☐Yes ☐No

Are you sexually active ? ☐Yes ☐No

Are you interested in being screened for STD's ? ☐Yes ☐No

Advanced Directive:
Do you have and Advanced Directive or Healthcare Proxy? ☐Yes ☐No

Colonoscopy or Cologuard:_____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date: _____Last Mammogram Date: _____

Date of last menstrual period or menopause: _____Bone Density:_____

Number of pregnancies: ____ Number of Births: ____

Vaccines:

Pneumonia:_____ Flu: _____Covid: _____ TDAP:_____

Other:_____

PAST MEDICAL HISTORY

Have you ever been told you had one of the following? Please check Yes if have now or have had in the past.

	Yes	No		Yes	No		Yes	No
Allergies	☐	☐	Diabetes Mellitus Type 1	☐	☐	Lung Disease	☐	☐
Anemia	☐	☐	Diabetes Mellitus Type 2	☐	☐	Mental Illness	☐	☐
Anxiety	☐	☐	Diabetic Complications	☐	☐	Movement Disorder	☐	☐
Arthritis	☐	☐	Endocrine Disease	☐	☐	Nerve Disease	☐	☐
Asthma	☐	☐	Eye Problems	☐	☐	Osteopenia/Osteoporosis	☐	☐
Autoimmune Disease	☐	☐	Gastritis/Ulcer	☐	☐	Overweight/Obesity	☐	☐
Back/Neck Pain	☐	☐	GERD/Acid Reflux	☐	☐	Pneumonia	☐	☐
Blood Disorder	☐	☐	Headaches/Migraine	☐	☐	Prostate Disorder	☐	☐
Bowel Disease	☐	☐	Hearing Loss	☐	☐	Spine Disease	☐	☐
CAD	☐	☐	Heart Rhythm Disorder	☐	☐	Stroke/TIA	☐	☐
CHF	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐
COPD	☐	☐	Hypertension	☐	☐	Tuberculosis/Pos PPD	☐	☐
Cancer	☐	☐	Hyperlipidemia	☐	☐	Urinary Problems	☐	☐
Dementia	☐	☐	Kidney Disease/Stones	☐	☐	Viral Disease	☐	☐
Developmental	☐	☐	Liver	☐	☐	Other:		
Depression	☐	☐						

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

FAMILY HEALTH HISTORY

	RELATION	SIGNIFICANT HEALTH PROBLEMS
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Preferred Pharmacy_____ Location_____

Phone_____

Alternate Pharmacy_____ Location_____

Phone_____

Allergies:_____

MEDICATIONS

Name	**Dosage**	**Direction**