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Phone: 562-696-1655 | Fax: 562-696-3755
www.BeWellIC.com

Patient Intake Form

How did you hear about us?

☐ Google | ☐ Yelp! | ☐ Facebook | ☐ Flyer | ☐ Outside Sign | ☐ Patient Referral | Other:_____

Patient Information

Patient Name: _____
Last First Middle

Patient Address: _____
Street City State Zip

Home Telephone: _____ Mobile Telephone: _____ Work Telephone: _____

Social Security Number: _____ Email Address: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Pharmacy Information

Pharmacy Name: _____ City/State: _____ Phone: _____

Cross Streets: _____

Primary Care Physician (PCP) Information

Physician Name: _____ City/State: _____Phone: _____

☐ Yes, please provide the consultation report from today's visit to my PCP.

☐ No, do not provide the consultation report from today's visit to my PCP.

Parent / Legal Guardian Name(s) (If patient is a minor)*

Parent/Legal Guardian Name: _____ Relation to Patient: _____

Parent/Legal Guardian Name: _____ Relation to Patient: _____

*Please note if you are not the parent or legal guardian of the patient, you must have a note that is signed and dated by the parent or legal guardian.

Emergency Contact Not Living with Patient:

Name: _____ Phone Number: _____

Relation to Patient: _____

Consent for Treatment of **(Patient Name)** _____ **(Date of Birth)** _____

I am giving consent on my own behalf or on the behalf of my child, for BeWell Immediate Care and its medical staff to treat the existing condition that is requiring medical attention. This includes, but is not limited to routine diagnostic procedures, tests and any other medical procedures that are deemed necessary by the medical staff. I understand that, absent emergency or extraordinary circumstances, if further consent for tests or treatments is necessary and warranted by my/my child's condition, the procedure(s) will be explained to me by the physician or his/her representative as appropriate, and further consent will be sought from me at that time.

Adult Patients

_____ _____
Patient Signature Today's Date

Minor Patients (to be completed by parent / legal guardian)

_____ _____ _____
Printed Name Signature Today's Date

Release of Medical Information

If requested, BeWell Immediate Care will release copies of your/your child's medical records to your primary care physician or other requesting entities for medical and/or treatment purposes in accordance with Health Insurance Portability and Privacy Act (HIPPA). Information will only be released with proper authorization. I understand that BeWell shall not publish or otherwise make generally available any protected health information or data that identifies a patient for purposes other than treatment or health care operations without his/her expressed written consent.

Privacy Disclosure

BeWell Immediate Care is a subsidiary of Montes Medical Group, Inc. The information shared with and obtained by BeWell Immediate Care and its staff members will be stored on the secured database of Montes Medical Group, Inc. This information will be protected in accordance with the Health Insurance Portability and Privacy Act (HIPPA).

Financial Responsibility

I understand that BeWell's services are cash based and I am financially responsible for my/my child's treatment.

Minor Consent for Treatment

BeWell Immediate Care will not examine your child unless a parent, legal guardian, or authorized adult is present during the exam. If you would like to allow an adult aside from the parent or legal guardian to accompany your child, please write a detailed letter including

- the name of the patient,
- the date of the clinic appointment, and
- the name of the authorized adult

and send with the authorized adult to present at the visit. All letters must be signed and dated by the parent or legal guardian. The authorized adult must present photo identification.

Medical History

Reason for Visit: _____

_____

Allergies and reactions: _____

_____

_____

What medication(s) are you currently taking?

Prescriptions	Over the counter	Herbal supplements

Please check to indicate if you have ever had any of the following conditions:

☐ Diabetes	☐ Emphysema	☐ Coronary Artery Disease	
☐ High Blood Pressure	☐ Stroke	☐ Heart Attack	
☐ Thyroid Disease	☐ Depression	☐ Arrhythmia	
☐ Kidney Disease	☐ Congestive Heart Failure	☐ Asthma	
☐ Hepatitis	☐ Tuberculosis	☐ Seizures	☐ Arthritis

☐ Eye Problems Type: _____

☐ Cancer Type: _____

☐ Sexually Transmitted Diseases Type: _____

☐ Other Type: _____

If you have any other medical problems or serious injuries not listed above, please describe them here:

_____

_____

Please list any surgeries or hospital stays you have had and their approximate date/year:

	Type of surgery/reason for hospitalization/location	Date
1.		
2.		
3.		
4.		