REVOLUTIONARY HEALTH SERVICES

# Patient Information Form

This purpose of this form is to learn more about YOU, our patient. This will assist our healthcare team in providing you with personalized service and the important information you need to make informed decisions regarding your overall health.

Today's Date (MM/DD/YY): _____ / _____ / _____

## Patient Information

Name: _____
First Middle Last

Home Address: _____
Street Address City, State Zip

Date of Birth (MM/DD/YY): _____ / _____ / _____

Home Phone: ( _____ ) _____ - _____ Cell Phone: ( _____ ) _____ - _____

Email Address: _____

Spouse: _____
First Middle Last

Cell Phone: ( _____ ) _____ - _____ Work Phone: ( _____ ) _____ - _____

Children: _____

Occupation: _____

Place of Employment: _____

Preferred Local Pharmacy/Location: _____

Pharmacy Phone: ( _____ ) _____ - _____

Insurance: _____ Member Number: _____

## Emergency Contacts

Name: _____

Phone: ( _____ ) _____ - _____ Relationship: _____

Name: _____

Phone: ( _____ ) _____ - _____ Relationship: _____

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**Communication Preferences**

How do you prefer to communicate for ***routine correspondence***?

☐ Email ☐ Home Phone ☐ Cell Phone

Would you like us to ***text*** you, when appropriate?

☐ Yes ☐ No

So that we may personalize the care you receive, please tell us which of the following are most important to you? (check all that apply)

☐ Clear and concise explanation of the problem and recommended solutions
☐ Detailed information about everything that is going on, regardless of severity
☐ Minimize conversation - - just tell me what to do
☐ Handling only my most pressing needs
☐ Contacting me after my appointment to follow up
☐ Contacting to remind me of my appointment time

**Scheduling**

What is your ***ideal*** appointment time?

☐ Early mornings (before 9 a.m.)
☐ Mornings (between 9 a.m. - 12 p.m.
☐ Afternoons (between 12 p.m. - 5 p.m.)
☐ Evenings (between 5 p.m.- 7 p.m.)
☐ Weekends

**Values**

What are the values you are most looking forward to in your new physician? (check all that apply)

☐ Coordination of care
☐ Health "quarterback"
☐ Quick access
☐ Easy access
☐ Problem solve current issues
☐ Assess and minimize genetic risk factors
☐ Availability when a crisis occurs
☐ A trusted advisor
☐ Take time with me
☐ Manage multiple medical concerns

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## Your Health

What concerns do you have regarding your ***current health***?

_____

_____

_____

_____

What concerns do you have about having a ***healthy future***?

_____

_____

_____

_____

What ***additional information*** would you like us to know at this time?

_____

_____

_____

_____

To assist us in requesting records on your behalf, please list your current physicians below.

| Name of Doctor | Specialty | Office Phone Number |
|---|---|---|
| | Primary Care Physician | |
| | | |
| | | |
| | | |
| | | |
| | | |