Dr. Rudy V. Byron
2405 Northwestern Avenue
Lower Level Suite 15
Racine, WI 53404

Welcome To Our Office!

Name: ____ Today's Date: _________/__________/____________
First Middle Last
Home Address: ____

City: _______________________________________ State: __________________________________ Zip: ________________________

Home Phone: ( ) _______________-_________________ Cell Phone: ( ) ________________-__________________

Email Address: ____ May we contact you here? (circle) YES / NO

Birthdate: ___________/____________/________________ Age: ______________ SSN: ____________-___________-______________

Employer: ____ May we contact you at work? (circle) YES / NO

Employer's Address: ____

City: _______________________________________ State: __________________________________ Zip: ________________________

Work Phone: ( ) _____________-______________ Years employed: ______________ Occupation: ______________________

Name of Spouse: ____

Birthdate: ___________/____________/________________ Age: ______________ SSN: ____________-___________-______________

Employer: ____

Employer's Address: ____

City: _______________________________________ State: __________________________________ Zip: ________________________

In Case of Emergency Contact: ____ Relationship: ____________________________

Home Phone: ( ) ________________-_________________ Cell Phone: ( ) ________________-_________________

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: ____ Relationship to Patient: ________________________________

Address: ____

City: _______________________________________ State: __________________________________ Zip: ________________________

Home Phone: ( ) ________________-_________________ Cell Phone: ( ) ________________-__________________

Email Address: ____ May we contact you here? (circle) YES / NO

Birthdate: __________/____________/________________ Age: ______________ SSN: ____________-___________-______________

Employer: ____ May we contact you at work? (circle) YES / NO

Employer's Address: ____

City: _______________________________________ State: __________________________________ Zip: ________________________

Work Phone: ( ) _____________-______________ Years employed: ______________ Occupation: ______________________

How did you hear about Byron Health & Healing? ____

Do you wish correspondence to be confidential? (circle) YES / NO Do you wish phone calls to be confidential? (circle) YES / NO

Family Practice New Patient Intake Form

Reason for Visit: ____

Past Medical History:

Please review the list below and check any problems you have had now or in the past:

Condition		Condition		Condition	
Abnormal Pap Smear		Eczema		Osteopenia	
Acne		Emphysema		Osteoporosis	
ADD / ADHD		Frequent UTI's		Positive TB Skin Test	
Alcohol abuse		Frequent Sinus Infections		Prostate Problems	
Anemia		Gallstones		Psoriasis	
Anxiety Disorder		Glaucoma		Reflux (heartburn)	
Asthma		Gout		Rheumatoid Arthritis	
Bipolar Disorder		Heart Attack		Rosacea	
Blood Clot		Heart Condition (specify)		Seasonal Allergies	
Blood Transfusion		Hepatitis (specify A,B,C)		Seizures	
Cancer (What kind?)		High Blood Pressure		Sexually Transmitted Disease (specify)	
Chronic Bronchitis		High Cholesterol			
Crohn's Disease or IBS		Kidney Disease		Stomach Ulcers	
Colon Polyps		Kidney Infections		Stroke	
Depression		Kidney Stones		Tuberculosis	
Diabetes		Lupus		Thyroid Disease	
Diverticulitis		Melanoma or Skin Cancer		Ulcerative Colitis	
Drug Abuse		Migraines		Warts	
Eating Disorder		Osteoarthritis			

Other medical problem not on list: ____

Please check or list all of the **SURGERIES** you have had:

	Type of Surgery	Year
	Appendectomy	
	Arthroscopy (joint)	
	Back or Neck Surgery	
	Cataract Surgery	
	Cesarean Section	
	Gallbladder Removal	
	Heart Surgery (specify)	
	Hemorrhoids	
	Hernia	

	Type of Surgery	Year
	Hysterectomy	
	Knee or Hip Replacement	
	Mastectomy or Lumpectomy	
	Polyp Removal (colon)	
	Tonsillectomy/ Adenoidectomy	
	Tubal Ligation or Vasectomy	
	Plastic Surgery (specify)	
	Other (specify)	

Current Medications: (Please include over the counter medications and food supplements.)

Drug Name:	Dose:	How Often?

Drug Name:	Dose:	How Often?

Are you **ALLERGIC** to any medications? **Yes / No**

Drug Name:	Reaction:

NAME: ____

For Women:

Last menstrual period	/ /
Last pap smear n/a	/ /
Last mammogram n/a	/ /
Last bone density	/ /

Age of first period	
# of days in cycle	
# of days in flow	
Are you menopausal	Y N
Age at onset of menopause	

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

Family History: Have any of your family members had any of the following problems?

X	Condition:	Family member:
	Heart Disease / Attack	
	Stroke	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid Disease	
	Depression	
	Other Mental Illness	
	Alcoholism	
	Asthma	

X	Condition:	Family member:
	Osteoporosis	
	Migraines	
	Breast Cancer	
	Colon Cancer	
	Prostate Cancer	
	Lung Cancer	
	Ovarian Cancer	
	Uterine Cancer	
	Skin Cancer	
	Other Cancer (specify)	

Any other illness in the family not listed? ____

Social History:

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

Highest Level of Education: ☐ 6th grade ☐ Jr. High ☐ High School ☐ College

☐ Graduate School ☐ Professional

Occupation: ____

If you have children, please list their names and ages:

____

Health Habits:

1. Do you currently smoke? ☐ Yes ☐ No If so, how much? ____ cig/day
   # of years smoking ____

   If no, did you smoke in the past? ☐ Yes ☐ No How many years? ____

   How much? ___ pk/day

   Quit date ______

   Are you exposed to smoke? ☐ Yes ☐ No

   Any other tobacco use? ☐ Yes ☐ No Type: ☐ Cigars ☐ Chewing tobacco

   ☐ Snuff ☐ Other

2. Do you drink caffeine? ☐ Yes ☐ No If so, how much? ____________________
3. Do you drink Alcohol? ☐ Yes ☐ No What kind? ☐ Beer ☐ Wine ☐ Liquor

   If so, how many times? ☐ Other __________________
   ____ week ____ month ____ year

   Have you ever had a problem with alcohol in the past? (legal or social)

   ____

4. Have you ever used street drugs? ☐ Yes ☐ No

   Which ones? ☐ Marijuana ☐ IV drugs ☐ Amphetamines ☐ Cocaine ☐ Heroin

   ☐ Downers ☐ Inhalants ☐ Other __________________

   Are you still using? ☐ Yes ☐ No

5. Are you sexually active? (in the last year) ☐ Yes ☐ No

   If yes, check all that apply ☐ 1 partner ☐ multiple partners

   ☐ Male partner(s) ☐ Female partner(s)

   Which birth control do you or your partner use? ☐ None ☐ Condoms ☐ The Pill

   ☐ Vasectomy / Tubal ☐ Other __________________

6. Do you exercise? ☐ Yes ☐ No If so, what type and how often? __________________
7. Do you eat out at restaurants weekly? ☐ Yes ☐ No Times per week _______
8. How many servings of fruits and vegetables do you get per day? 0 1 2 3 4 5 more than 5
9. Do you take a calcium supplement? ☐ Yes ☐ No Number of dairy servings per day: ______
10. Do you wear a seatbelt? ☐ Yes ☐ No
11. Do you have a living will? (do not resuscitate, medical power of attorney) ☐ Yes ☐ No Please ask for info.
12. Is there concern for your safety? (emotional, physical, or sexual abuse) ☐ Yes ☐ No

NAME: ________________________________

Dr. Rudy V. Byron
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Insurance Information

Name: ____ Today's Date: ____________________________
First Middle Last

Primary Insurance

Name of Insurance Company: ____

Address: ____

City: _________________________________ State: ____________________________ Zip: ___________________

Insured's Name: ____

Group Number: ____________________________________ Policy ID Number: ____________________________

Secondary Insurance

Name of Insurance Company: ____

Address: ____

City: _________________________________ State: ____________________________ Zip: ___________________

Insured's Name: ____

Group Number: ____________________________________ Policy ID Number: ____________________________

Rudy V. Byron, Jr. M.D.
2405 Northwestern Avenue
Lower Level Suite 15
Racine, WI 53404
P: 262 672 6393
F: 262 672 6206

Appointment Cancellation Policy Agreement:

Patient Name:____

Please call us at (262) 672-6393 by 2:00 p.m. two days (48 hours) prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Wednesday***. If the 48 hour prior notification is not given, we must apply a ***$75.00*** charge for the ***missed appointment***.

The Office of Dr. Byron is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Thank you.

Please sign below to consent to these terms.

X____

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Medical Information Release and Health Information Privacy Notice Form
(HIPAA RELEASE FORM)

Patient Name:____Date of Birth: _________________

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- [ ] Spouse: ____
- [ ] Child(ren):____
- [ ] Other: ____

[ ] Information is not to be released to anyone.

This notice is effective as of the date signed. This authorization will expire seven years after the date on which you last received services from the clinic.

Messages

Our office does like to confirm your reserved time prior to your appointment day. We may occasionally need to leave a voicemail message or leave a message with a family member for you to call our office. Our office also uses an online communication portal called Hello Health for secure messaging.

Please indicate your communication preference below:

Please call: [ ] My Home [ ] My Work [ ] My Cell: ________________________

[ ] My E-Mail:____

If you are unable to reach me:

- [ ] You may leave a detailed message
- [ ] Please leave a message asking me to return your call
- [ ] Other: ____

The best time to reach me is (*day*)___________________________________between (*time*) ____________________

Signed:____Date:______________________________