FACULTY INTERNAL MEDICINE

VISIT FORM

Today's Date: _____ Date of Birth: _____

Name: _____ Doctor: _____

Why Was this Visit Initially Scheduled?

Please note the ***single*** best reason:

To become a ***new*** patient and I

☐ have a medical *problem or symptom*

☐ would like a *physical* or *well-visit exam*

I am an **established** patient in this practice and

☐ would like an annual *physical* or *well-visit exam*

☐ have a *new* medical problem

☐ am here to *follow-up* on an ongoing medical issue (like diabetes or high blood pressure)

Although we wish we had enough time at each visit to address all of a patient's concerns, our schedules allot only a certain amount of time. Your insurance company may also cover each visit type differently. We regret that we will be unable to alter the visit type or the coding that we use to communicate with your insurance company after your visit.

Do you have any particular symptoms or concerns of which you want your provider to be aware?

_____

_____

Yes	No	
☐	☐	Would you like to review your Patient Privacy Questionnaire Contact Record so that you may update whom we are allowed to contact on your behalf?
☐	☐	Do you have a Living Will?
☐	☐	Would you like information on a Living Will?

Signature: _____

Pharmacy Name and Number: _____