Clinton REGIONAL HOSPITAL

New Patient Intake Form

Please complete the following information. All fields are required unless specified.

Patient Information

Full Name
First Name: _____
Middle Name: _____
Last Name: _____

Date of Birth
MM/DD/YYYY: _____

Gender
☐ Male
☐ Female
☐ Other: _____

Social Security Number
SSN: _____
(*This may be optional depending on patient preference and clinic policy in Oklahoma*)

Race (Optional)
☐ Asian
☐ Black or African American
☐ Native American or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Prefer not to answer
☐ Other: _____

Ethnicity (Optional)
☐ Hispanic or Latino
☐ Other: _____
☐ Prefer not to answer

Preferred Language
☐ English
☐ Spanish
☐ Other: _____

Address
Street Address: _____
City: _____
State: Oklahoma
ZIP Code: _____

Phone Numbers
Home: _____
Mobile: _____
Work: _____

Email Address: _____

Insurance Information

Primary Insurance Provider
Insurance Company Name:
_____
Policy Number:
_____
Group Number:
_____

Secondary Insurance Provider (if applicable)
Insurance Company Name:
_____
Policy Number:
_____
Group Number:
_____

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Do you have any known allergies (medications, food, environmental)?
☐ Yes
☐ No

If yes, please list:

_____

Family Health History

Please check any health conditions that are common in your family:

☐ Diabetes
☐ Heart Disease
☐ Hypertension (High Blood Pressure)
☐ Stroke
☐ Cancer
☐ Mental Health Disorders (e.g., Depression, Anxiety)
☐ Autoimmune Disorders (e.g., Lupus, Rheumatoid Arthritis)
☐ Other:

_____

Lifestyle & Social History

- **Do you smoke?**
  ☐ Yes
  ☐ No
  ☐ Former smoker (quit in _____)
- **Do you drink alcohol?**
  ☐ Yes
  ☐ No
  If yes, how often?
  _____
- **Do you use recreational drugs?**
  ☐ Yes
  ☐ No
  If yes, please describe:
  _____
- **Exercise:**
  ☐ Regularly
  ☐ Occasionally
  ☐ Never
- **Diet:**
  ☐ Balanced
  ☐ Poor
  ☐ Other:
  _____
  Would like to discuss
- **Living Situation:**
  ☐ Live Alone
  ☐ With Family
  ☐ With Others

HIPAA Privacy Notice Acknowledgment

I acknowledge that I have received and understand the HIPAA Notice of Privacy Practices for the clinic. I am aware that my medical information will be kept confidential according to HIPAA regulations.

☐ Yes
☐ No

Signature:

_____
Patient or Legal Guardian