

# LEGACY WELLNESS TELEHEALTH – INTAKE FORM

Patient Full Name:

Date of Birth:

Address:

Reason for Visit:

Allergies:

Current Medications:

Pharmacy (Name & Address):

Past Surgeries:

Recent Hospitalizations:

Vital Signs (BP / HR / RR / Temp / O2):

Height:

Weight:

Social History:

Family History:

HIPAA Privacy Notice:

Legacy Wellness Telehealth complies with all federal HIPAA privacy laws. Your personal health information will be kept confidential and used only for treatment, payment, and healthcare operations.

Patient Consent:

By signing below, I acknowledge that the information I provided is accurate and I authorize Legacy Wellness Telehealth to collect, use, and disclose my health information for the purpose of providing medical care.

Signature:

Date: