Patient Verification/Medication List

For your safety please fill out form completely at every visit

Patient Name_____ Date of Birth_____Today's Date_____

Current Phone #_____

Address_____City_____State_____Zip_____

Email_____Please provide your email. You will receive a link to access your records on patient portal.

Primary Insurance_____Secondary Insurance_____

Pharmacy Name _____Pharmacy Phone_____

Pharmacy Location_____

Drug Allergies _____ € none

Current Medications € none

Name	Strength	Dosage	Name	Strength	Dosage
1._____			7. _____		
2._____			8._____		
3._____			9._____		
4._____			10._____		
5._____			11._____		
6._____					
12._____					

Current smoker: ___ no ___yes, How long have you smoked? _____ How many packs per day? _____
Previous smoker: ___no ___ yes, When did you quit?_____
Have you had an influenza shot (flu shot)? ___no ___ yes, when?_____
Have you had a pneumonia shot? ___no ___yes, when?_____

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To be completed by office staff:

Smoking Cessation: CPT 99406

BMI: Exercise (dx Z71.3)

High BP: Refer to PCP, lifestyle change, weight, diet, physical fitness

Dr. Baker Signature:_____ Dr. Young Signature:_____