Orchard Medical Center, S.C. (OMC)
Appointment Intake Questionnaire Screening Form
Please Print – Complete ONE Form for EACH Patient

Today's Date_____ **Current** MD_____

PATIENT INFORMATION & APPOINTMENT REQUEST

Patient's Last Name:	First:	Middle:	
Date of Birth:	Age:	Sex: Male☐	Female☐
Street Address:			
City:	State:	Zip:	Telephone:
Insurance Company:			
Do You Have a HMO Insurance: Yes: ☐ No: ☐	If Yes Are You With LCPA or APP		Yes: ☐ No ☐
Group Number:	Member ID:	Effective Date:	Name of Plan:
How Did You Hear About Us?			
What Do You Need An Appointment For?			
When Were You Seen By Your Current MD Last?			

CURRENT MEDICATIONS

List ANY Over The Counter Supplements You Are Taking Including Strength and Duration
List ANY Prescribed Medications You Are Taking Including Strength and Duration: :
1. Reason:
2. Reason:
3. Reason:
4. Reason:
5. Reason:
6. Reason:
7. Reason:

LIST ANY RECENT VISIT TO HOSPITAL, ER, ACUTE CARE CENTER, TAKE CARE CLINIC, WALK-IN CLINIC:

#1 Name of Facilty:	Reason for Visit:
Location of Facility You Received Care:	
Do You Have Paperwork From Your Visit?	Yes ☐ No ☐
#2 Name of Facilty:	Reason for Visit:
Location of Facility You Received Care:	
Do You Have Paperwork From Your Visit?	Yes ☐ No ☐
#3 Name of Facilty:	Reason for Visit:
Location of Facility You Received Care:	
Do You Have Paperwork From Your Visit?	Yes ☐ No ☐

Currently Under the Care of:

#1 Name of MD:	Reason for Care:
#2 Name of MD:	Reason for Care:
#3 Name of MD:	Reason for Care:
Patient Signature:	Date: