TRIAGE FORM

DATE TIME

NAME _____

DOB _____ **PHONE #** _____

PHARMACY _____ **ALLERGIES** _____

- Reason for Being Seen Today _____
- Symptoms _____
  - When did symptoms start? _____

CIRCLE ALL THAT APPLY TO YOUR MEDICAL HISTORY

Diabetes	Heart Problems	High Blood Pressure	Bleeding Disorder	Lung Disease
Thyroid Disorder	Immune Disease	High Cholesterol	Cancer	Stroke

- Current Medication List _____
  - _____
  - _____
  - _____
  - _____

INITIAL EACH STATEMENT IN ACKNOWLEDGEMENT OF INFORMATION

_____ I acknowledge the medical information above to be true, accurate, and complete.
_____ Please remember that insurance is considered a method of reimbursing the patient for fees paid to the Provider and is not a substitute for payment. In the case that I do not have insurance, my insurance denies, or partially pays my claim; I understand that I am fully responsible for any unpaid balance. I acknowledge that Cardinal Healthcare is out of network with some insurances, I understand that regardless of my insurance or out of network status, I am responsible for any amounts due to Cardinal Healthcare after processing of an insurance claim.
_____ I have received and understand Cardinal Healthcare's HIPPA and Privacy Practices information.

PATIENT/GUARDIAN SIGNATURE _____

CARDINAL HEALTHCARE STAFF TO COMPLETE

HEIGHT _____	WEIGHT _____	O2 LEVEL _____
B/P _____	PULSE _____	TEMP _____