MESO HEALTHCARE

Integrated Primary Care | Mental Health | Infectious Disease

Wayne C. Presutti, FNP-BC, PMHNP

8556 S Ashland Ave, Chicago, IL 60620
Phone: (312) 598-1887 | Fax: (312) 267-1062
Mon-Fri 9:00 AM - 5:00 PM
www.mesohealthcare.com

Please complete all sections. Bring this form, a valid photo ID, and your insurance card to your first appointment.

PATIENT DEMOGRAPHICS

Full Legal Name: _____

Preferred Name: _____ Date of Birth: _____

Sex Assigned at Birth: ☐ Male ☐ Female Gender Identity: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: _____

Email: _____ Preferred Contact: ☐ Phone ☐ Email

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____ Alt Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Member ID: _____ Group #: _____

Policyholder Name: _____ Relationship to Patient: _____

Secondary Insurance (if applicable): _____

☐ Self-Pay ☐ Medicare ☐ Medicaid ☐ Workers' Comp

REASON FOR VISIT

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MEDICAL HISTORY

Current Medications (name, dose, frequency):

Allergies (medications, food, environmental): _____

Past Surgeries / Hospitalizations: _____

Do you currently experience any of the following? (check all that apply):

- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Bipolar Disorder
- ☐ Substance Use
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ HIV / AIDS
- ☐ Hepatitis
- ☐ Chronic Pain
- ☐ Asthma / COPD

Other conditions: _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No ☐ Former

Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

If yes, specify: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____

PREFERRED PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____

I certify that the information provided is accurate and complete to the best of my knowledge. I authorize Meso Healthcare to use this information for my treatment, billing, and healthcare operations as described in the Notice of Privacy Practices.

_____ _____

Patient Signature (or Legal Guardian) Date