

Pentz Health Services LLC dba Navy Health  
**NEW PATIENT INTAKE FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Last, First)*

Mailing Address: \_\_\_\_\_  
*City State Zip Code*

Phone # (Cell/Home/Work): \_\_\_\_\_ Alternate Phone # (Cell/Home/Work): \_\_\_\_\_

Cell Phone Provider: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Do you have children?  Yes  No If yes, how many? \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Care Doctor?  None \_\_\_\_\_ Phone#: \_\_\_\_\_

Women: Any chance you could be pregnant?  Yes  No

How did you hear about our clinic? \_\_\_\_\_

**EMERGENCY CONTACT**

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

**INCIDENT INFORMATION**

Is this visit due to an accident?  Yes  No

*If yes, what type?*  Auto  Work  Other \_\_\_\_\_

Has the incident been reported?  Yes  No

*If yes, to whom?* \_\_\_\_\_

**Payment Method:** (Please Circle) - Self Pay / Health Insurance / Auto Insurance / Lawyer / Worker's Comp

**INSURANCE INFORMATION: (N/A )**

Insurance provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary Insured/ Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Secondary Insurance: (N/A ) \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_

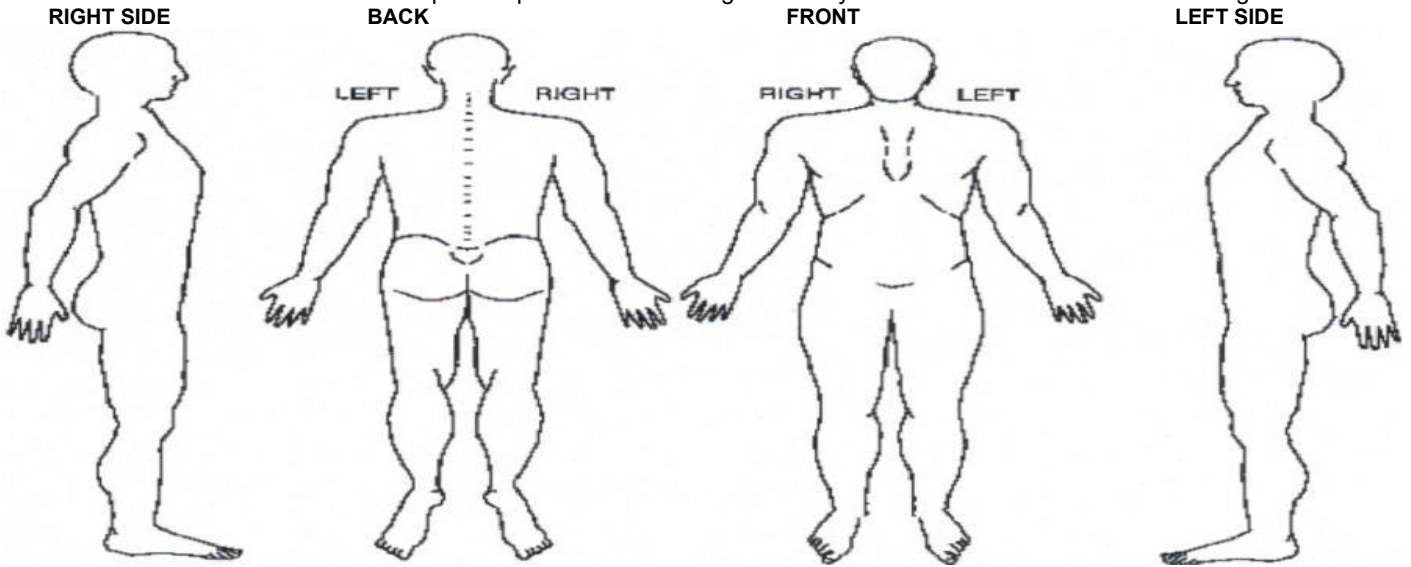
*Auto Accident Claim #:* \_\_\_\_\_ *Adjuster:* \_\_\_\_\_

Do any of the following below interest you today? (Please circle all that apply)

*Symptom Relief / Optimal Health / Massage / Weight Loss / Nutrition / Supplementation / Allergies*

Indicate on the body diagram where you are experiencing symptoms:

**N= Numbness – S=Sharp – Z=Spasms – B= Burning – X= Achy/Dull – W= Weakness – T= Throbbing**



**Problem Area #1**

**Problem Area #2**

How did the pain begin?		How did the pain begin?	
Have you had this pain before?	Yes/No If yes #of times:	Have you had this pain before?	Yes/No If yes #of times
Date the pain started		Date the pain started	
How often do you feel it?	0-25% 25-50% 50-75% 75-100%	How often do you feel it?	0-25% 25-50% 50-75% 75-100%
Pain scale (0= no pain)	0 1 2 3 4 5 6 7 8 9 10	Pain scale (0= no pain)	0 1 2 3 4 5 6 7 8 9 10
Quality (Sharp, Stabbing, Numb)		Quality (Sharp, Stabbing, Numb)	
Does the pain travel	Y / N, if so where?	Does the pain travel	Y / N, if so where?
What increases pain?		What increases pain?	
What decreases pain?		What decreases pain?	
Have you had X-rays? / MRI?	Yes / No	Have you had X-rays? / MRI?	Yes / No
What time is the pain the worst?	Night / Morning / Mid day / NA	What time is the pain the worst?	Night / Morning / Mid day / NA

**Problem Area #3**

**Problem Area #4**

How did the pain begin?		How did the pain begin?	
Have you had this pain before?	Yes/No If yes #of times:	Have you had this pain before?	Yes/No If yes #of times
Date the pain started		Date the pain started	
How often do you feel it?	0-25% 25-50% 50-75% 75-100%	How often do you feel it?	0-25% 25-50% 50-75% 75-100%
Pain scale (0= no pain)	0 1 2 3 4 5 6 7 8 9 10	Pain scale (0= no pain)	0 1 2 3 4 5 6 7 8 9 10
Quality (Sharp, Stabbing, Numb)		Quality (Sharp, Stabbing, Numb)	
Does the pain travel	Y / N, if so where?	Does the pain travel	Y / N, if so where?
What increases pain?		What increases pain?	
What decreases pain?		What decreases pain?	
Have you had X-rays? / MRI?	Yes / No	Have you had X-rays? / MRI?	Yes / No
What time is the pain the worst?	Night / Morning / Mid day / NA	What time is the pain the worst?	Night / Morning / Mid day / NA

Do you have Allergies?  Yes  No If yes, please list: \_\_\_\_\_

Are you taking any: Blood thinners  Yes  No Aspirin  Yes  No Non steroidal anti- inflammatory  Yes  No

Please list and date any surgeries you have had, and diseases you have been diagnosed with:  None \_\_\_\_\_

Please list any Doctors you are seeing or have seen, please include contact number: \_\_\_\_\_

Please state in your own words, the major medical reason(s) for coming in today:

Are you taking any: Medications?  Yes  No Supplements?  Yes  No  
Please list all medication, including dosage, that you currently use:

Do you have any drug allergies? Yes / No. If yes, please list: \_\_\_\_\_

**Family History;** Please indicate the health or cause of death of members of your family as best as you can:

	Age	Any serious diseases? Please list	Cause of Death, if applicable, and Age of death.
Mother			
Father			
Brothers			
Sisters			
Children			
Spouse			
Other			

Have you had any significant problems in the following areas? If yes, please provide additional comments and dates of issues.

Recent weight loss  Yes  No \_\_\_\_\_

Headaches  Yes  No \_\_\_\_\_

Trouble with vision  Yes  No \_\_\_\_\_

Trouble with hearing  Yes  No \_\_\_\_\_

**REVIEW OF SYSTEMS:** Check the ones you now have or have had in the past.

**General**

- Abnormal weight loss/gain
- Alcoholism/drug abuse
- Allergies
- Blood/bleeding problems
- Breast lumps/soreness
- Cancer
- Depression/anxiety
- Diabetes
- Excessive thirst
- Fever/chills without flu
- General fatigue
- Night sweats
- Poor sleep
- Thyroid disease/goiter

**Gastrointestinal**

- Abdominal pain
- Appendicitis
- Belching/gas
- Black/bloody stools
- Constipation
- Diarrhea
- Gallbladder problems
- Hemorrhoids
- Hernia
- Liver problems/jaundice
- Frequent nausea/vomiting
- Pain over abdomen
- Poor appetite
- Poor digestion
- Ulcer/heartburn

**Eye, Ear, Nose, and Throat**

- Deafness/difficulty hearing
- Dental problems
- Ear noises/ ringing
- Hoarseness
- Nosebleeds
- Nose problems
- Pain in/behind eyes
- Sinus problems/hay fever
- TMJ
- Tonsil problems
- Visual disturbances

**Cardio-Respiratory**

- Ankle swelling
- Asthma/wheezing
- Chest pains
- Chronic cough
- Difficulty breathing
- Emphysema
- High blood pressure
- High cholesterol levels
- Irregular heartbeat
- Previous heart trouble
- Rheumatic Fever
- Spitting phlegm/blood
- Stroke
- Tuberculosis
- Varicose veins

**Skin**

- Bruising easily
- Change in mole(s)
- Itching /eczema/rash
- Skin cancer

**Genitourinary**

- Blood in urine
- Difficulty starting flow
- Frequent urination
- Frequent night urination
- Inability to control flow
- Kidney disease/stones
- Painful urination
- Sexual difficulties
- Urinary tract infection
- Venereal infection

**Women Only**

- Are you pregnant**  Yes  No
- Excessive flow
- Irregular cycles
- Hot flashes
- Painful periods
- PMS
- Vaginal burning/itching
- # of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_
- Date last menstrual period began

**Men Only**

- Testicular swelling/pain
- Prostate problems

**Neurological**

- Convulsions
- Dizziness
- Fainting
- Headache
- Mental disorder
- Numbness/tingling
- Twitching/tremors/epilepsy
- Weakness

**Musculoskeletal**

- Neck pain
- Pain between shoulders
- Low back pain
- Hip/knee/ankle/foot pain (circle all that apply)
- Osteoporosis
- Rheumatoid arthritis
- Shoulder/elbow/wrist/hand pain (circle)
- Scoliosis

**Habits**

- Smoking \_\_\_\_\_ packs/day – years smoked \_\_\_\_\_
- Alcohol Drinks per week \_\_\_\_\_
- Exercise frequency \_\_\_\_\_
- Recreational drug use

**Family History**

(brothers, sisters, parents, grandparents only)

- Thyroid disease
- Cancer
- Diabetes
- High blood pressure
- Heart disease
- Stroke
- Kidney disease
- Muscle, bone, nerve, disease

*I certify that all of the above questions were answered accurately. I understand that providing incorrect information may be dangerous to my health.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, assign directly to Pentz Health Services LLC all insurance benefits, if any, payable for services rendered to my minor child or myself. I understand I am financially responsible for all charges whether or not paid by insurance.

Patient Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature (or Parent/ Guardian, if minor) \_\_\_\_\_

*If a patient is not yet 18 years old, a parent or guardian must sign.*

**CONSENT TO CARE**

As a patient in this office, I have the right to know the types of treatment Navy Health could possibly use and any complication/side-effects to such treatment. In rare cases, underlying physical defects, deformities or pathologies, may render the patient susceptible to injury. I am responsible for informing my doctors about any conditions, diseases, illnesses, etc. Navy Health will not provide specific treatments if they are aware that such care may be contraindicated. I hereby allow treatment to be rendered to myself by Pentz Health Services LLC dba Navy Health.

Patient Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature (or Parent/ Guardian, if minor) \_\_\_\_\_

*If a patient is not yet 18 years old, a parent or guardian must sign.*

**FINANCIAL POLICY**

I understand that I'm responsible for paying all deductibles, co-payments and co-insurance, and any non-covered services at the time of service. If I receive an insurance check, I agree to bring that check to the office within 7 business days. If the account is over 30/60/90 days past due, unpaid balances will be referred to a collection agency for resolution. I understand I will be assessed any and all collection fees incurred by the clinic.

\_\_\_\_\_ (initials)

**MISSED APPOINTMENT POLICY**

I understand there will be a \$50.00 fee charged for ALL appointments that are not canceled or rescheduled with a minimum of 24 hours advance notice. Please notify us as soon as possible to cancel an appointment.

\_\_\_\_\_ (initials)