Pentz Health Services LLC dba Nevy 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

SSN #: _______-_______-_______

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 □)

Primary Insurance Carrier:____

Primary Insured/ Policy Holder Name:____

Relationship to Patient: _____________________Date of Birth: ______/______/______

Policy ID:__________________Group #:___________________

Telephone:(___)______-______Fax:(____)______-______

Secondary Insurance: (N/A □) ____

Primary Insured/ Policy Holder Name:____

Relationship to Patient: _____________________Date of Birth: ______/______/______

Policy ID:__________________Group #:___________________

Telephone:(___)______-______Fax:(____)______-______

*Auto Accident Claim #:*__________________________*Adjuster:*______________________________________

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This form should be placed in the patient's medical record

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Name:______________________________

HEALTH HISTORY

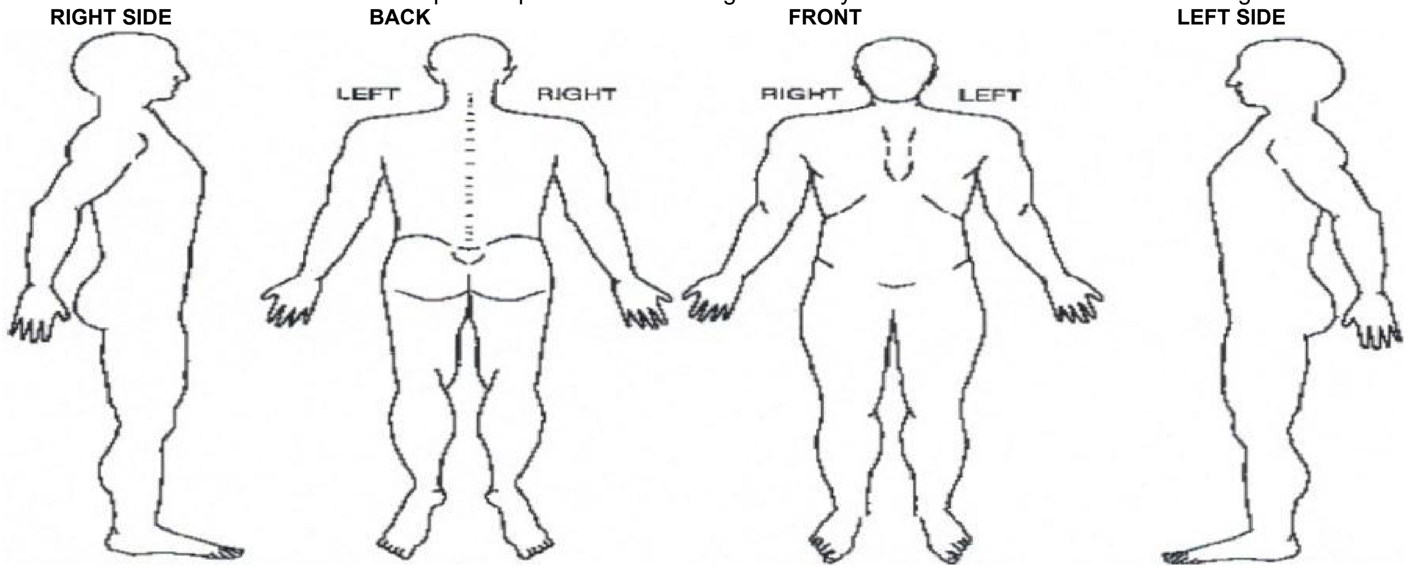
Do any of the following below interest you today? (Please circle all that apply)

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

RIGHT SIDE **BACK** **FRONT** **LEFT SIDE**



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

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HEALTH HISTORY

*Name:*_______________________________

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 ____

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6402 E. Superstition Springs Blvd Suite 123 – Mesa AZ 85206 – Revision III – January 1, 2018

*Name:*______________________________

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 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.

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*Name:*______________________________

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.

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.
Medicare Patients: Medicare doesn't cover everything. If you need certain services Medicare doesn't cover, you'll have to pay for them yourself unless you have other insurance or you're in a Medicare health plan that covers them.
You may get a written notice called an "Advance Beneficiary Notice of Non-coverage" (ABN) from your doctor or other health care provider. However, an ABN isn't required for items or services that Medicare never covers.

___________________ (initials)

CONSENT TO CARE

As a patient in this office, I have the right to know the types of treatment Nevy 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. Nevy 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 Nevy Health.

___________________ (initials)

APPOINTMENT REMINDER POLICY

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, texts, or health information to me as an extension of my care in this office.

____________________ (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)

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