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

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.*

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_

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. As a courtesy, Pentz Health Services dba Nevy Health will attempt to verify your health insurance benefits and/or necessary authorizations for you. Please be aware. this is only "A **QUOTE** of Benefits/Authorizations." **We cannot guarantee payment or verify that definite eligibility of benefits conveyed to us or to you by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, and exclusions of the member's contract at the time of service.** Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Our office will make every effort to bill your insurance in a timely manner. If your carrier determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service and it will become your responsibility. We recommend you to be familiar with and verify your benefits with your insurance company prior to your services at Pentz Health Services dba Nevy Health. Please be aware, that even then, it is still not a guarantee of benefits or payment. (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)

APPOINTMENT REMINDER/ TEST 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 including test results as an extension of my care in this office

_____ (initials)

ACKNOWLEDGMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Pentz Health Services LLC dba Nevy Health's Notice of Privacy Practices.
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.

If completed by a patient's personal representative, please print and sign your name in the space below

Personal Representative Printed Name:_____Date:_____
Personal Representative's Signature:_____
Relationship:_____

I authorize _____ (name) relationship _____ to obtain all/any health information regarding my care at Pentz Health Services dba Nevy Health. This authorization may include disclosure of information relating to alcohol, drug abuse, mental illness and confidential HIV related information only if I put my initial next to each box. I have the right to revoke this authorization at any time in writing to my health care provider. I understand that I may revoke this authorization except to extent that action has already been taken based on the authorization.

_____Entire Medical Records
_____ Alcohol/Drug Treatment
_____ HIV related Information
Other:_____
_____ Mental Health Information
_____ Genetic Testing

For Office Use Only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

Does Patient have a copy of the Privacy Notice? □ Yes □ No

If answered "No" above, I have made a good faith effort to obtain a written acknowledgment of receipt of Pentz Health Services LLC dba Nevy Health's Notice of Privacy Practices but was unable to for the following reason:
□ Patient refused to sign □ Patient unable to sign □ Other_____

Employee Printed Name:_____Date:_____
Employee's Signature: _____

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

*Name:*_____

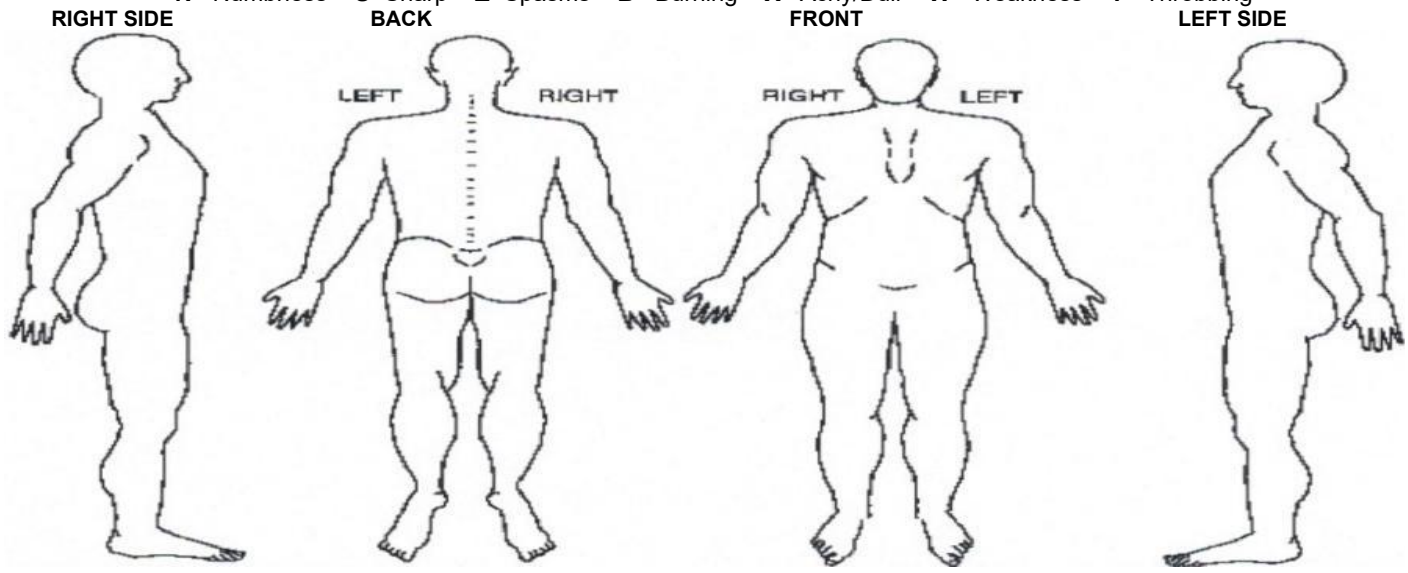
HEALTH HISTORY

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



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 _____

*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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