NEW PATIENT FORM (A)

Today's Date: _____

Referring Doctor: _____ Address: _____

Primary Doctor: _____ Address: _____

Patient Information

Name: _____ Social Security Number: _____

Street Address: _____ Date of Birth: _____ Age: _____

City/State/Zip: _____ Height: _____ Weight: _____ lbs

Preferred Phone: _____ Secondary Phone: _____

Email: _____ Driver's License # / State: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Gender: ❑ Male ❑ Female

Race: ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report Primary Language: ❑ English ❑ Spanish ❑ Other

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your primary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Drug Abused

Drug	Past/Current	IV/Oral/Smoke	How Much/Dose	How Often/Frequency	Date of Last Use
Alcohol					
Cocaine					
Heroin					
LSD / Hallucinogens					
Marijuana					
Opioid Pain Killers					
Meth Amphetamines					
Benzodiazepines					
Ecstasy / Crystal Meth					
Amphetamines					

❑ Hydrocodone (Lortab / Lorcet / Norco / Vicodin) ❑ Oxycodone (Percocet / Oxycontin / Roxicodone)
❑Oxymorphone (Opana) ❑ Fentanyl (Duragesic patch/Fentora/Actiq) ❑Dilaudid ❑Morphine ❑Methadone ❑Tramadol
❑Codeine ❑Buprenorphine (Suboxone)

Pertinent History

Have you had psychiatric or psychological evaluation or treatment for any of these conditions?
❑ Anxiety ❑ Depression ❑ ADHD ❑ Bipolar disorder ❑ Personality disorder ❑ Addiction treatment

Have you ever had any of the following? ❑ DWI ❑ Arrested for possession of drugs ❑ Court ordered drug treatment

Have you ever considered suicide? ❑ Yes ❑No When? _____
Have you ever planned suicide? ❑ Yes ❑No When? _____
Have you ever attempted suicide? ❑ Yes ❑No When? _____

Past Treatment

Have you taken Suboxone before? ❑ Yes ❑ No ❑ Currently taking _____ mg
Have you taken Methadone before? ❑ Yes ❑ No ❑ Currently taking _____ mg
Have you taken Vivitrol before? ❑ Yes ❑ No ❑ Currently taking _____ mg

Have you participated in an inpatient or outpatient treatment programs including addiction counseling? ❑ Yes ❑ No
Do you have any support system? ❑ Family/Friends ❑ Support group (AA/NA) ❑Religious services ❑ Other_____

Tobacco, Alcohol & Drug History

Alcohol Use:
❑ Don't Drink Alcohol ❑ Drink Alcohol Socially ____ / week (Beer/Wine/Whiskey/Hard Liquor)
❑ Drink Alcohol Daily (Beer/Wine/Whiskey/Hard Liquor) How much? _____
❑ Past History of Alcoholism ❑ Past treatments including AA?: _____

Tobacco Use: ❑ Non Smoker ❑ Current Tobacco Smoker _____PPD ❑ Ex-Smoker ❑ Chew Tobacco

Drug Use: ❑ Current Illegal Drug Use? ❑ Currently taking _____❑ Past Illegal Drug Use _____

Drug Overdose History: ❑ Yes ❑ No What Drug? _____ Treatment _____

Suboxone / Methadone treatment: ❑ Yes ❑ No ❑ When? _____

Current Medications

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? ❑Yes ❑No

Medication Name	Allergic Reaction Type

Topical Allergies: ❑ Iodine ❑ Latex ❑ Tape Are you allergic to shellfish? ❑ Yes ❑ No

Past Surgical History

❑ Laparoscopy _____
❑ Hemorrhoid surgery _____
❑ Hernia repair _____
❑ Valve replacement _____
❑ Heart Bypass _____
❑ Laminectomy _____
❑ Appendix removed _____
❑ Cesarean section _____
❑ Hysterectomy _____
❑ Spinal fusion (levels) _____
❑ Gallbladder removal _____
❑ Other _____

Family History

	Mother	Father		Mother	Father
Arthritis	❑	❑	Kidney Problems	❑	❑
Cancer	❑	❑	Liver Problems	❑	❑
Diabetes	❑	❑	Osteoporosis	❑	❑
Heart Disease	❑	❑	Rheumatoid Arthritis	❑	❑
High Blood Pressure	❑	❑	Seizures	❑	❑
High Cholesterol	❑	❑	Stroke	❑	❑

Past Medical History

General Medical
❑ Cancer – Type _____
❑ Diabetes – Type _____
❑ HIV / AIDS
❑ Hyperthyroidism
❑ Hypothyroidism

Head/Eyes/Ears/Nose/Throat
❑ Headaches
❑ Migraines
❑ Head Injury
❑ Glaucoma

Cardiovascular / Hematologic
❑ Anemia
❑ Atrial Fibrillation
❑ Bleeding Disorders
❑ Blood Clots
❑ Coronary Artery Disease
❑ Cong. Heart Failure
❑ Heart Attack
❑ High Blood Pressure
❑ High Cholesterol
❑ Mitral Valve Prolapse
❑ Murmur
❑ Pacemaker
❑ Poor Circulation
❑ Stroke/ TIA

Respiratory
❑ Asthma
❑ Bronchitis
❑ Emphysema / COPD
❑ Pneumonia
❑ Tuberculosis

Gastrointestinal
❑ Bowel Incontinence
❑ Cirrhosis
❑ Constipation

❑ GERD (Acid Reflux)
❑ Gastrointestinal Bleeding
❑ Hepatitis A / B / C
❑ Hernia
❑ Irritable Bowel Syndrome
❑ Ulcers

Musculoskeletal

❑ Amputation
❑ Carpal Tunnel Syndrome
❑ Chronic Low Back Pain
❑ Chronic Neck Pain
❑ Chronic Joint (arthritic) Pain
❑ Degenerative Disc Disease
❑ Fibromyalgia
❑ Osteoarthritis
❑ Osteoporosis
❑ Rheumatoid arthritis
❑ Spinal Stenosis
❑ Compression Fracture

Genitourinary/Nephrology

❑ Bladder Infection
❑ Kidney failure
❑ Kidney Disease
❑ Kidney Stones
❑ Urinary Incontinence

Neuropsychological

❑ Alcohol Abuse
❑ Alzheimer Disease
❑ Anxiety
❑ Bipolar Disorder
❑ Depression
❑ Epilepsy
❑ PTSD

Patient Acknowledgement & Signature

I certify that the above information is accurate, complete and true. I understand that no guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent to retrieve and review my medication history. I understand that this will become part of my medical record. **X Patient Initials: _____**

AFTER HOURS POLICY: Clinic hours are from Monday to Friday from 9am to 5pm. **THERE IS NO ANSWERING SERVICE.** If you call after office hours, your call will be answered on the next business day. Please allow up to 48 hours to respond. For any urgent matter or in case of Emergency, please call 911 or go to the nearest Emergency room or Hospital. **X Patient Initials: _____**

HIPAA-PATIENT CONSENT FORM: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of our HIPAA practices. **X Patient Initials: _____**

FINANCIAL POLICY

1. Patient's portion of payment, including co-pay, deductible or balance on account is due at the time services are rendered unless prior arrangements have been made with the Billing Department.
2. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier. We verify your benefits as a courtesy; it does not guarantee coverage or payment.
3. If the insurance company does not pay your balance in full within 30 days of bill submission, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
4. Returned checks will be subject to a $25 collection charge.
5. Completion of forms is subject to a $25 charge.
6. No show or cancellations without 24 hours notice are subject to $25 charge.
7. Unpaid balances over 90 days may be subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

Patient name: _____ Date: _____

Signature: _____ Date: _____