New Patient Intake Form

Patient's Legal Name: ____

First Middle Last

Date of Birth: ______________________ Sex / Gender: ___________________

Age: ____________ Social Security # (for insurance verification) ________________

Address:____

City:_______________________ State:__________________ Zip:_____________

Preferred phone:____________________ Alternate phone:_____________________

Email address:____

Emergency Contact's Name: ____

Relationship to patient:___________________ Phone: _________________________

Insurance Information

Primary insurance company: ______________________ Member ID: _____________

Group #: _____________________ Customer service phone #: _________________

Secondary insurance company: ____________________ Member ID: _____________

Group #: _____________________ Customer service phone#: _________________

Statement of Insurance Assignment and Release of Information

I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.
I authorize payment of medical benefits directly to Dr.Nora Aaron, ND, LLC.
I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due.

Signature: ___________________________ Date:______________________

What are your biggest health concerns you would like to discuss today?

______________________________________Concern

When did it start?	How frequent?	Mild/Moderate/Severe?	
Abdominal pain	*two weeks ago*	*once a day*	*mild*
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

What prescription medications are you taking? (Prescriptions and OTC)

Medication & Dosage	Reason	Date Started	Prescribing Dr
Prilosec 20mg before meals	*acid reflux*	*June 2009*	*Dr. Smith*
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

What supplements / vitamins are you taking?

Name & Dosage	Reason	Date Started	Recommended by
Probiotics 1 capsule a day	*digestive issues*	*June 2009*	*Self*
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

Previous surgeries and hospitalizations? ______________________________

____

Have you ever been diagnosed with a chronic medical condition (heart disease, diabetes, cancer, etc)? ____

____

Do you have any allergies to medications, foods or environmental allergens? ___________

____

Are you seeing other healthcare providers? _____________________________________

____

Primary Care Provider: ____

Review of Systems (please circle answer)

____

Y= Yes, present condition N=No, never had this condition P= past condition

General

Dizziness Y P N Night Sweats Y P N Fatigue Y P N
Weight gain Y P N Weight loss Y P N Stress Y P N

Head / Ears / Eyes

Headaches Y P N Migraine headaches Y P N Jaw/TMJ problems Y P N
Head trauma Y P N Ringing in ears Y P N Diminished hearing Y P N
Eye Pain Y P N Vision changes Y P N Blurring of vision Y P N

Skin / Hair

Rashes Y P N Ance / Rosacea Y P N Eczema
Y P N
Spots that are changing color or growing larger Y P N Thinning hair Y P N
Psoriasis Y P N Skin dryness Y P N Changes in nails Y P N

Nose / Mouth

Nose bleeds Y P N Congestion Y P N Tooth pain Y P N

Neck / Throat

Throat pain Y P N Lumps/ bumps Y P N Difficulty swallowing Y P N
Neck pain Y P N Neck stiffness Y P N

Chest / Lungs

Cough Y P N Shortness of breath Y P N Difficulty breathing Y P N
Wheezing Y P N Pain with breathing Y P N

Cardiovascular
Chest pain Y P N | High Blood pressure Y P N | Irregular heart beat Y P N
Swelling of feet or lower legs Y P N | Shortness of breath when laying down Y P N

Abdomen / Digestion
Diarrhea Y P N | Constipation Y P N | Abdominal Pain Y P N
Heartburn Y P N | Nausea/Vomiting Y P N | Blood in stool Y P N

Urinary
Incontinence Y P N | Pain with urination Y P N | Urinary frequency Y P N
Dribbling Y P N | Frequent infections Y P N | Urinary Urgency Y P N

Neurological
Seizures Y P N | Memory changes Y P N | Loss of coordination Y P N
Tremor Y P N | Paralysis Y P N | Numbness / Tingling Y P N

Mental / Emotional
Depression Y P N | Anxiety Y P N | Panic Attacks Y P N
PTSD Y P N | Mood swings Y P N | Sleep changes Y P N

Musculoskeletal
Joint Pain Y P N | Muscle weakness Y P N | Limited range of motion Y P N
Muscle cramps Y P N

Male Reproductive
Hernias Y P N | Testicular mass Y P N | Sexual difficulty Y P N

Female Reproductive
Pelvic pain Y P N | Vaginal discharge Y P N | Difficulty conceiving Y P N
Cramping Y P N | Spotting Y P N | Pain with menses Y P N
Age of first menses: ______________ Age of last menses (if menopausal): __________
Length of cycle: _________________ Date of last annual exam: _________________
Number of pregnancies: __________ Number of live births: ____________________
Number of miscarriages: __________ Number of abortions: _____________________

Consent for Treatment

I do hereby give my consent for services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient Dr. Nora Aaron. I give my consent to be examined and treated by Dr. Nora Aaron.

I have fully read and understand the above agreements and authorizations.

____
Patient's Name (Print) Date

____

Patient's Signature

HIPAA Notice of Privacy Policy

I hereby consent to the use and disclosure of my Protected Health Information by Dr. Nora Aaron for the purposes of treatment, payment and healthcare operations, or as otherwise required by law. Dr. Nora Aaron has provided copied of her Notice of Privacy Practices which provides more detailed information about the usage and disclosure of my Protected Health Information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice. I have the right to request restrictions to the usage and disclosure of my Protected Health Information. I have the right to request an alternative to the standard method of communication of my Protected Health Information.

____

Printed name Date

____

Patient signature