LA Healthcare
& ASSOCIATES

Leah Ashe DNP, FNP-BC
523 US HIGHWAY 321 NW HICKORY, NC 28601
(P): 828-569-1600 (F): 980-748-2991

In order to continue to provide excellent care to our current patients and yet make the office available for patients who do not currently have a medical provider, we need to gather some information to determine how quickly we can fit you into our schedule based on illness, severity, and complexity of your needs. Please understand **that this office does not accept patients who are being seen for chronic pain management.** You must agree in writing that you **are not taking and will not request Hydrocodone, Oxycodone, Percocet, Dilaudid, Morphine or any similar long-term narcotic pain medication.** All pain management patients will be referred to pain management and you must agree in writing that you will never ask Leah Ashe, FNP-BC for those medications. All patients will be checked on the state website to verify whether or not you are taking chronic pain medications from other providers. Patients requiring medications such as **Valium, Ativan, or Xanax need to know in advanced that those medications also will not be provided through this office but will be provided only upon referral to Behavioral Health or psychiatry.**

I agree that I am not taking any of the above medications, or generic equivalent, and will not request these medications at any time while being cared for by Leah Ashe, FNP-BC.

Name: ____

Date of birth ___/___/____

Address: ____

City: ______________________________________ State _______ Zip __________

Cell Phone: ____________________________

Home Phone: ______________________ Work Phone: ______________________

Place of Employment: ____

Signature: _____________________________________ Date: ______________

Where you and your family matter.

Patient Intake Form

Account # ________________ Name of Employer: ______________________________
First Name: _____________ Middle Initial:_____ Last Name: ____________________
Mailing Address: ____
Home Phone: ________________Mobile Number: ______________________________
Email Address: _____________________Sex: _____ Marital Status:________________
Birth date: ____________ SSN: _________________
Ethnicity: (check one) Hispanic or Latino ____ Not Hispanic or Latino_____________
Race: (check one) American Indian/ Alaskan Native _____Asian_____
African American____Native Hawaiian____Other____Bi-Racial______
Primary Care Provider: ____
Preferred Language: ______________

How did you hear about us?

- ☐ Work of Mouth
- ☐ DMV Ad
- ☐ Google Search
- ☐ Referral
- ☐ Road Sign
- ☐ At an Event
- ☐ Website
- ☐ Drove by the office

Emergency Contact______________________Relationship__________________

Do you authorize LA Healthcare to obtain the last 12 months of your medication history from your pharmacy?

- ☐ Yes
- ☐ No

****TO PROCESS YOUR INSURANCE CLAIM, YOU MUST COMPLETE THIS SECTION****

Name of Insurance: _____________________Policy Number_____________
Group Number_________Policy Holder__________Policy Holder Date of Birth__________
Police Holder SSN: ____________________ Policy Holder Employer___________________

Assignment of Benefits: I hereby authorize LA Healthcare & Associates to examine me, including ordering additional testing, labs, or imaging as deemed necessary by exam findings. I acknowledge I am legally responsible for all charges in connection with the medical care and treatment provided by LA Healthcare & Associates. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State/Federal Law.

Patient/Representative Signature: ____________________________Date: ____________

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Date of birth ___/___/____

Address: ____

City: _______________________________________ State ______ Zip _________

Cell Phone: ____________________________

Home Phone: ______________________ Work Phone: ______________________

Place of Employment: ____

Signature: _____________________________________ Date: ______________

Where you and your family matter.

Health History Questionnaire

Patient Name: ______________________________Date of Birth: _______________
Reason for today's visit: ____
Previous Primary Care Provider: _____________________Pharmacy:_____________

Allergies	**Reaction**

Medications:
Please list all medications including over-the-counter medications, vitamins, and inhalers

Drug Name	**Strength**	**Frequency**

Family Health History (check all that apply, please specify type of cancers)

	Maternal Grandmother	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**	**Father**	**Mother**	**Brother**	**Sister**
Heart Disease								
Cancer								
Diabetes								
Stroke								
Hypertension								
Depression								
Osteoporosis Mental illness								
Other (specify)								

Social History

Current Occupation: ________________________
Marital Status: (check one) Married____Single____Divorced_____Separated____Widow____
Do you have an advanced directive? (Health care power of attorney / Living will): YES/NO
Exercise level: None____Occassional_____Moderate_____Heavy_____
Diet: Regular_____Vegetarian_____Vegan_____Gluten free_____Diabetic______
Caffeine: None_____Occasional_____Moderate_____Heavy_______
Alcohol: None_____<3x a week______>3x a week______Heavy______
Stress level: Low_____Medium_____High_____
Drugs: Do you currently use any recreational or street drugs? YES/NO
If yes, please specify: ____

Do you use tobacco? YES/NO
If not currently, did you ever use tobacco? YES/NO

- ☐ Cigarettes ___pks/day
- ☐ Chew_____/day
- ☐ Cigars_____/day
- ☐ # of years _____or year quit______

Past Surgical history	Reason	Year	Hospital

Obstetric and Gynecological History
Age of first menstrual period: _____
Age at first child: _____
Date of last menstrual period or age of menopause: _____
Date of Last Pap Smear: ___________
Date of last mammogram: _________
Number of pregnancies: _____births______miscarriages______abortions______
Check all that apply:

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Breast lump or nipple discharg
- ☐ Hot flashes
- ☐ Extreme menstrual pain
- ☐ Painful intercourse

Past Medical History (check all that apply)

- ☐ ADD or ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bedwetting
- ☐ Bleeding disorder
- ☐ Blood clots or DVT
- ☐ Blood disease
- ☐ COPD
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Congenital Abnormalities
- ☐ Constipation
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Developmental or Behavioral Disorders
- ☐ Diabetes – Insulin
- ☐ Diabetes –Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Ear or hearing problems
- ☐ Eczema or other skin condition
- ☐ Erectile dysfunction
- ☐ Fibromyalgia
- ☐ GERD/reflux
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart problems
- ☐ Hiatal hernia
- ☐ High cholesterol
- ☐ Hospital admission
- ☐ High blood pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leg/foot ulcers
- ☐ Liver disease
- ☐ Muscle, joint, bone disorder
- ☐ Osteoporosis
- ☐ Pulmonary embolism
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vision Problems

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION: I give permission to release the health information of:

Patient Name: ____ Date of Birth: _____________________

Release information FROM:

____

List applicable Facility(s) and/or Practice(s)

____

Phone Number Fax Number

Release information TO:

____

Name of facility

____

Address

____

Phone Number Fax Number

PURPOSE OF RELEASE (check reason):

- ☐ Request of individual/personal representative
- ☐ Continued patient care
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Other ___________________________________

Fill in dates of treatment for records to be released:

Treatment dates: From ________________ To _____________________

Office/Clinic/Hospital Care (check all that apply):

- ☐ Office Notes
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Immunization Records
- ☐ Medication list

Signature: ______________________________ Print Name: __________________________ Date: ________

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS PATIENT REQUESTS