JIAO FENG CLINIC – New Patient Packet

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Instructions for New Patients

To prepare for your first visit, please complete the following essential forms and return them to our office before your appointment.

Forms to complete:
1. New Patient Intake Form
2. Combined Consent Form
3. Financial Policy Agreement
4. Assignment of Benefits
5. Email/Text Communication Consent

You may return your completed forms by:
- Fax: 301-838-5956
- Bringing them to your appointment

Please also bring:
- A copy of your insurance card (front and back)
- A photo ID

New Patient Intake Form

Full Name: _____

Date of Birth: _____

Gender: _____

Social Security Number: _____

Phone Number: _____

Email Address: _____

Home Address: _____

Preferred Language: _____

Race: _____

Ethnicity: _____

Marital Status: _____

Employment Status: _____

Employer: _____

Referred by: _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Insurance Information

Primary Insurance: _____

Member ID: _____

Group Number: _____

Policy Holder: _____

Policy Holder's DOB: _____

Relationship to Patient: _____

Secondary Insurance (if any): _____

Pharmacy Information

Preferred Pharmacy Name: _____

Address / Cross Streets: _____

Phone Number: _____

Allergy Information

☐ No Known Drug Allergies

☐ Allergic to: _____

Type of Reaction: _____

☐ Environmental Allergies: _____

☐ Food Allergies: _____

Social History

Do you smoke? ☐ Never ☐ Former Smoker ☐ Current Smoker – Packs/day: _____

Alcohol use? ☐ No ☐ Occasionally ☐ Regularly – Drinks/week: _____

Recreational drug use? ☐ No ☐ Yes – Type: _____

Caffeine use? ☐ No ☐ Yes – Cups/day: _____

Exercise frequency ☐ Never ☐ 1–2 times/week ☐ 3–5 times/week ☐ Daily

Family Medical History (parents, grandparents, siblings)

Please add relationship and onset age

☐ High Blood Pressure ☐ Stroke ☐ Cancer – Type: _____

☐ Diabetes ☐ heart disease

☐ Depression/Anxiety
☐ Mental Illness
☐ kidney disease
☐ Thyroid Disease
☐ Other: _____

Personal Medical History

☐ High Blood Pressure
☐ Diabetes
☐ Asthma
☐ COPD
☐ Stroke
☐ Seizures
☐ heart disease
☐ High Cholesterol
☐ Depression/Anxiety
☐ Thyroid Disorder
☐ Cancer – Type: _____
☐ kidney disease
☐ Autoimmune Disease
☐ Other: _____

Surgical History

1. _____
2. _____
3. _____

Hospitalizations

1. _____
2. _____
3. _____

Immunization History

☐ COVID-19
☐ Flu Shot (Annually)
☐ Pneumonia
☐ Tetanus (Tdap)
☐ Hepatitis A
☐ Hepatitis B
☐ Shingles (Zoster)
☐ MMR
☐ HPV
☐ Other: _____

Current Medications

Medication/Supplement name	Dosage	Frequency	Reason

Reason for Visit / Current Concerns

_____

_____

_____

Patient Acknowledgment

I certify that the information provided is complete and accurate to the best of my knowledge. I understand that this information will be kept confidential and used only for my care.

Signature: _____ Date: _____

Combined Consent Form

General Consent to Treat

I consent to medical evaluation and treatment by Jiao Feng Clinic.

I understand I have the right to ask questions and decline any services.

HIPAA Authorization

I authorize Jiao Feng Clinic to disclose my medical information for treatment, billing, and operations.

I understand this authorization remains valid for one year unless revoked in writing.

Medical Records Release

I authorize the release of my medical records from or to another provider for continuity of care.

AI Consent

I consent to the use of AI tools for clinical documentation, including voice transcription or support.

I may revoke this consent at any time in writing.

Telehealth Consent

I consent to participate in telehealth visits using secure video or phone communication.

I understand the limitations and risks and may withdraw at any time.

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Financial Policy Agreement

I understand that I am financially responsible for all charges not covered by insurance.
This includes copays, deductibles, and non-covered services.

- Copays are due at the time of service.
- Late cancellations (less than 24 hours) and no-shows may incur a fee of $25–$50.
- Insurance claims are filed as a courtesy. If unpaid after 60 days, I will be billed.

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Assignment of Benefits

I authorize my insurance company to pay benefits directly to Jiao Feng Clinic for services rendered.
I understand that I am financially responsible for any balance not covered.

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Email/Text Communication Consent

I consent to receive appointment reminders, lab results, and non-urgent health information via:

☐ Email ☐ Text Message ☐ Both

I understand that these may not be secure communication channels. I can revoke this consent in writing at any time.

Phone for Texts: _____
Email: _____

Signature: _____ Date: _____

Patient Name: _____ DOB: _____