TRANSFORMATIVE HEALTHCARE INTAKE FORM

NAME DOB AGE DATE

SEX

ADDRESS

CITY, STATE, ZIP

HOME PHONE NO. CELL PHONE NO. WORK PHONE NO.

MARITAL STATUS: Single Married Widowed Divorced Separated

SSN:

PATIENT'S EMPLOYER

EMPLOYMENT STATUS full time part time retired unemployed STUDENT STATUS full time part time N/A

EMERGENCY CONTACT PHONE NO. RELATION TO PATIENT

PERSON RESPONSIBLE FOR BALANCE RESPONSIBLE PARTY'S DOB

RESPONSIBLE PARTY'S ADDRESS RESPONSIBLE PARTY'S SSN

EMAIL ADDRESS

RACE/ETHNICITY White African-American Hispanic Asian American Indian Alaskan Native Pacific Islander

PREFERRED LANGUAGE

PHARMACY Local pharmacy name/telephone no.

Mail order pharmacy name/telephone no.

INSURANCE INFORMATION (COPIES OF INSURANCE CARDS REQUIRED)

PRIMARY INSURANCE EFFECTIVE DATE

NAME OF INSURED/SUBSCRIBER RELATIONSHIP TO PATIENT

INSURED'S DATE OF BIRTH INSURED'S ID NO. GROUP NO.

SECONDARY INSURANCE EFFECTIVE DATE

NAME OF INSURED/SUBSCRIBER RELATIONSHIP TO PATIENT

INSURED'S DATE OF BIRTH INSURED'S ID NO GROUP NO.

Assignment of Insurance Information & Benefits/Release of Medical Information: I hereby authorize the staff of Transformative Healthcare, LLC to administer/perform any treatment deemed necessary, and authorize release of information needed to secure payment. I authorize that all benefits by my insurance company be paid directly to Transformative Healthcare, LLC and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. In addition, I hereby authorize the release of all applicable medical information including & without limitation copies of all records and test results produced to the designated attending, referral and /or follow-up physicians and such other health care practitioners or organizations who/which will be providing subsequent monitoring of care or treatment in connection with care provided by Transformative Healthcare, LLC.

Signature of Responsible Party_____ Date _____

Acknowledgement of Privacy Practice and Patient Rights

1. Patient Rights: A copy of my Patient Rights has been made available to me.
2. Notice of Privacy Practice: A copy of Transformative Healthcare, LLC Notice of Privacy Practice has been made available to me.

_____ _____ _____

Signature of Patient (or Legal Guardian/Representative) Date Relationship to Patient

☐ Patient unwilling or unable to sign acknowledgement Reason

HAVE YOU DESIGNATED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?
If yes, please provide a copy for your healthcare provider.
DO YOU HAVE ANY RELIGIOUS OR CULTURAL BELIEFS THAT MAY IMPACT YOUR HEALTHCARE (religious affiliations)?
If yes, describe

I BEST LEARN NEW INFORMATION BY: CIRCLE THE FOLLOWING: VERBAL INSTRUCTION WRITTEN INSTRUCTION HANDOUTS PICTURES

Level of education completed: Circle the following: 8th grade 12th grade 1-4 years of college >4 years of college

NAMES AND PHONE NUMBERS OF HEALTH CARE PROVIDERS SEEN IN LAST 12 MONTHS

NAMES	PHONE NUMBERS

LIST MEDICATIONS, SUPPLEMENTS, HERBS, VITAMINS, OVER THE COUNTER MEDS

MEDICATION NAME	DOSE	INSTRUCTIONS

LIST AND DESCRIBE ALL ALLERGIC REACTIONS TO FOODS, MEDICATIONS, OR BEE STINGS

FOOD, MEDICATION, INSECT ALLERGY	REACTION TYPE	WHEN

OCCUPATION AND ANY WORK-RELATED HEALTH EXPOSURES (asbestosis, chemicals ect.)

OCCUPATION	LOCATION	WORK-RELATED HEALTH EXPOSURES

HOBBIES

EXERCISE

TYPE	MINUTES/WEEK

HAVE YOU TRAVELED IN THE LAST YEAR

TRAVEL INSIDE UNITED STATES	DATES
TRAVEL OUTSIDE UNITED STATES	DATES

VACCINATION HISTORY DATES

INFLUENZA	
PREVNAR 13	
PNEUMOVAX	
TD OR TDAP	
ZOSTAVAX	
OTHER	

TOBACCO USE

TYPE	LENGTH OF USE	FORMER OR CURRENT

ALCOHOL USE

DO YOU DRINK ALCOHOL? IF YES, CIRCLE ONE. CURRENT OR FORMER

IF CURRENT HOW MANY DRINKS PER DAY, PER WEEK, OR PER MONTH

RECREATIONAL DRUG USE

HAVE YOU EVER USED DRUGS FOR RECREATION? IF YES, CIRCLE ONE? CURRENT OR FORMER

LIST THE RECREATIONAL DRUGS AND WHEN USED

STD RISK FACTORS

Are you or have you ever been sexually active?

Do you use birth control?

How many sexual partners in the last year?

Do you prefer relationships with males, females, or both genders?

Do you identify as male or female?

Have you ever been diagnosed with a sexually transmitted disease?

PREVENTATIVE HEALTH

LAST PAP SMEAR

LAST MAMMOGRAM

LAST PSA LEVEL

LAST PROSTATE EXAM

LAST COLONOSCOPY

LAST BONE MINERAL DENSITY

FEMALE PATIENTS ONLY

HAVE YOU EVER BEEN PREGNANT?

OF PREGNANCIES

OF LIVE BIRTHS

OF MISCARRIAGES/ABORTIONS

PAST SURGICAL HISTORY

SURGICAL PROCEDURE	DATES

PAST MEDICAL HISTORY

DIAGNOSIS	YEAR DIAGNOSED

FAMILY HISTORY (IMMEDIATE FAMILY, GRANDPARENTS, OTHER)

DIAGNOSIS	RELATIONSHIP

TRANSFORMATIVE HEALTH CARE NO SHOW POLICY

If you are unable to keep your appointment, YOU MUST CALL the office 24 hours in advance. Not cancelling 24hrs in advance or same day cancelling will result in a $25 fee. Fee must be paid at the next visit or 30 days from the date of missed appointment.

Patient Signature _____

Date _____

Voicemail Authorization

Can we leave health information on your personal voicemail? Please Circle Yes or No.

YES NO

Signature:_____ Date: _____

Consent to Share Health Information

Please list the people who we can share your health information with.
*This Consent is good for 1 year.

1. _____
2. _____
3. _____
4. _____
5. _____

Signature: _____ Date: _____