PATIENT INTAKE FORM

Date: _____

PATIENT INFORMATION

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Social Security Number: _____ Date of Birth: _____

Sex (Circle One): Male – Female – Transgender Language Preference: _____

Race (Circle One): American Indian/Alaska Native – Pacific Islander/Native Hawaiian – Asian
Black/African American – White/Caucasian – Patient Declined to Answer

Ethnicity (Circle One): Hispanic/Latino – Not Hispanic/Not Latino – Patient Declined to Answer

Marital Status (Circle One): Single – Married – Divorced – Widowed – Separated – Other

PATIENT HOME ADDRESS

Street Address: _____

Street Address: _____

City, State, Zip Code: _____

PATIENT CONTACT INFORMATION

Home Phone Number: _____ Fax Number: _____

Cell Phone Number: _____

Email Address: _____

Preferred Method of Contact (Circle One): Home Phone – Cell Phone – Email – Fax

PATIENT EMPLOYMENT INFORMATION

Occupation: _____

Employer Name: _____

Street Address: _____

City, State, Zip Code: _____

Work Phone Number: _____ Work Fax Number: _____

Work Email Address: _____

PATIENT EMPLOYMENT STATUS (Circle One)

Full Time – Part Time – Self Employed – Unemployed – Disabled – Retired – Student FT – Student PT

Other: _____

GUARANTOR INFORMATION (Please complete if the guarantor is a person other than the patient.)

A guarantor is the person that is financially responsible for the fees associated with this patient's bill.

Relationship to Patient (Circle One): Spouse – Parent – Child – Sibling – Legal Guardian – Primary Care Giver – Other Relative: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Social Security Number: _____ Date of Birth: _____

Sex (Circle One): Male – Female – Transgender Language Preference: _____

Home Street Address: _____

Home Street Address: _____

City, State, Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Email Address: _____

Preferred Method of Contact (Circle One): Home Phone – Cell Phone – Email – Fax

EMERGENCY CONTACT INFORMATION

Relationship to Patient (Circle One): Spouse – Parent – Child – Sibling – Legal Guardian – Friend Primary Care Giver – Other Relative: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Date of Birth: _____ Sex (Circle One): Male – Female – Transgender

Home Street Address: _____

Home Street Address: _____

City, State, Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Email Address: _____

Preferred Method of Contact (Circle One): Home Phone – Cell Phone – Email – Fax

PRIMARY CARE PHYSICIAN

Physician Name: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Referring Physician Name (if different from above): _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy City, State: _____

POLICY HOLDER – INSURANCE INFORMATION

Relationship to Patient (circle one if other than patient):

Spouse – Parent – Child – Sibling – Legal Guardian – Primary Care Giver – Other Relative: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Social Security Number: _____ Date of Birth: _____

Sex (Circle One): Male – Female – Transgender

Home Street Address: _____

Home Street Address: _____

City, State, Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Email Address: _____

Preferred Method of Contact (Circle One): Home Phone – Cell Phone – Email – Fax

PRIMARY INSURANCE HEALTH PLAN INFORMATION

Health Plan Name: _____

Billing Street Address: _____

City, State, Zip Code: _____

Member Number: _____ Group Number: _____

Effective Date: _____ Phone Number: _____

SECONDARY INSURANCE HEALTH PLAN INFORMATION (if applicable)

Health Plan Name: _____

Billing Street Address: _____

City, State, Zip Code: _____

Member Number: _____ Group Number: _____

Effective Date: _____ Phone Number: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Greenhouse Integrative Medicine, LLC to furnish all necessary information to my insurance providers concerning my (or my dependent's) illness and treatment. I hereby authorize and assign to Greenhouse Integrative Medicine, LLC, its treating physicians, and its staff all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any co-payments for the office visit as designated by my insurance provider. I understand that it is my responsibility to ensure that procedures/surgeries are part of my contract with my insurance provider and I am responsible for payment if my insurance provider does not cover the designated procedure(s).

Patient Full Name: _____ **Date:** _____

Signature of Patient/Parent/Legal Guardian: _____

FOR MEDICARE PATIENTS: I hereby authorize Greenhouse Integrative Medicine, LLC to provide all necessary information to my insurance carriers concerning my illness and treatment. I hereby authorize and assign to Greenhouse Integrative Medicine, LLC, its treating physicians, and its staff all payments for medical services rendered to me.

Patient Full Name: _____ **Date:** _____

Signature of Patient/Parent/Legal Guardian: _____

MEDICAL AND NUTRITIONAL HISTORY

PAST MEDICAL HISTORY

Allergies to Medications (Circle One): YES NO If YES, complete the following:

Medication: _____ Type of Reaction: _____

Medication: _____ Type of Reaction: _____

Medication: _____ Type of Reaction: _____

Medication: _____ Type of Reaction: _____

Medication: _____ Type of Reaction: _____

Medication: _____ Type of Reaction: _____

Medication: _____ Type of Reaction: _____

Allergies to Foods (Circle One): YES NO If YES, complete the following:

Food: _____ Type of Reaction: _____

Food: _____ Type of Reaction: _____

Food: _____ Type of Reaction: _____

Food: _____ Type of Reaction: _____

Food: _____ Type of Reaction: _____

Food: _____ Type of Reaction: _____

Food: _____ Type of Reaction: _____

Allergies to Other (Circle One): YES NO If YES, complete the following:

Type or Substance: _____ Type of Reaction: _____

Type or Substance: _____ Type of Reaction: _____

Type or Substance: _____ Type of Reaction: _____

Type or Substance: _____ Type of Reaction: _____

Type or Substance: _____ Type of Reaction: _____

Type or Substance: _____ Type of Reaction: _____

Type or Substance: _____ Type of Reaction: _____

Please circle any and all problems or conditions you have had with, or related to, any of the following:

Abnormal Discomfort	Drug Abuse	Osteoporosis
Alcohol Abuse	Gallbladder Disease	Palpitations
Anemia	Gout	Persistent Cough
Anxiety	Hay Fever	Phlebitis
Arthritis	Head or Neck Radiation	Pneumonia
Asthma	Headache	Rheumatic Fever
Blood Disorders	Heart Disease	Shortness of Breath
Blood In Stool	Hemorrhoids	Skin Diseases
Bronchitis	Hepatitis	Swollen Ankles
Cancer	High Blood Pressure	Thyroid Disease
Change In Bowel Habits	High Cholesterol	Tuberculosis
Chest Pain/Tightness	Jaundice	Ulcers
Colitis	Kidney Disease	Unexplained Weight Changes
Constipation	Kidney Stones	Urination Issues
Diabetes	Lightheadedness	Vascular Disease
Diarrhea	Lower Back Problems	Venereal Disease
Depression	Non-Healing Wounds	Other: _____

PAST HOSPITALIZATIONS AND SURGICAL HISTORY

Hospitalizations

Hospital: _____ Reason: _____ Year: _____

Hospital: _____ Reason: _____ Year: _____

Hospital: _____ Reason: _____ Year: _____

Hospital: _____ Reason: _____ Year: _____

Hospital: _____ Reason: _____ Year: _____

Hospital: _____ Reason: _____ Year: _____

Hospital: _____ Reason: _____ Year: _____

Surgeries

Surgery: _____ Reason: _____ Year: _____

Surgery: _____ Reason: _____ Year: _____

Surgery: _____ Reason: _____ Year: _____

Surgery: _____ Reason: _____ Year: _____

Surgery: _____ Reason: _____ Year: _____

Surgery: _____ Reason: _____ Year: _____

Surgery: _____ Reason: _____ Year: _____

ONGOING MEDICAL CONDITIONS

(asthma, AIDS, cancer, diabetes, heart diseases, kidney failure, lung diseases, migraine headaches)

Condition: _____ Year of Diagnosis: _____

Current Medications: _____

Other Treatments: _____

Condition: _____ Year of Diagnosis: _____

Current Medications: _____

Other Treatments: _____

Condition: _____ Year of Diagnosis: _____

Current Medications: _____

Other Treatments: _____

PSYCHOLOGICAL AND BEHAVIORAL HISTORY

(psychiatric disorders, sociological disorders, substance abuse and/or addiction, anxiety, depression)

Condition: _____ Year of Diagnosis: _____

Current Medications: _____

Other Treatments: _____

Condition: _____ Year of Diagnosis: _____

Current Medications: _____

Other Treatments: _____

Condition: _____ Year of Diagnosis: _____

Current Medications: _____

Other Treatments: _____

FAMILY MEDICAL HISTORY

Have any of your family members, including parents, grandparents, children, siblings, aunts/uncles, and cousins, had any of the following illnesses?

Breast Cancer	Autoimmune Disorder	Osteoporosis
Cervical Cancer	Bleeding Disease	Sickle Cell Anemia
Colon Cancer	Diabetes	Strokes
Ovarian Cancer	Genetic Disease	Thyroid Disease
Prostate Cancer	Heart Disease	
Uterine Cancer	Hypertension	

Mental/Psychiatric Disease (anxiety, bipolar disorder, borderline personality disorder, depression)

Illness: _____ Family Member: _____

Approximate Age of Diagnosis: _____

Illness: _____ Family Member: _____

Approximate Age of Diagnosis: _____

Illness: _____ Family Member: _____

Approximate Age of Diagnosis: _____

Illness: _____ Family Member: _____

Approximate Age of Diagnosis: _____

Illness: _____ Family Member: _____

Approximate Age of Diagnosis: _____

Illness: _____ Family Member: _____

Approximate Age of Diagnosis: _____

NUTRITIONAL HISTORY

Do you regularly consume fruits and vegetables? YES NO

Do you drink, on average, eight (8) cups of water per day? YES NO

Dietary Concerns: _____

_____

_____

Special Dietary Needs: _____

_____

_____

SOCIAL HISTORY AND HABITS

Do you drink coffee? YES NO How many cups per day? _____

Do you drink tea? YES NO How many cups per day? _____

Do you smoke cigarettes? YES NO How many cigarettes per day? _____

Do you drink alcoholic beverages? YES NO How many drinks per day? _____

Do you use recreational drugs? YES NO

Which kinds of recreational drugs do you use? _____

How often do you use each recreational drug listed above? Please explain in the space provided below.

_____

_____

_____

_____

_____

IMMUNIZATION HISTORY

Have you had Pneumovax? YES NO IF YES, when? _____

Have you had Tetanus? YES NO IF YES, when? _____

THE FOLLOWING SECTION APPLIES TO WOMEN ONLY

Are you currently pregnant? YES NO

Do you believe that you may be pregnant? YES NO

Do you currently plan to get pregnant? YES NO

Are you currently breastfeeding? YES NO

What is the date or approximate date of your last menstrual cycle? _____

GYNECOLOGIC AND OBSTETRIC HISTORY

What was your age at the onset of periods? _____

How frequent are your periods? _____

What is the average length of your periods? _____

Number of pregnancies: _____ Number of births: _____

Number of miscarriages: _____ Number of elective abortions: _____

Have you had issues with any pregnancies? YES NO

Please describe: _____

_____

Have you had prolonged or abnormal bleeding at any time? YES NO

Please describe: _____

_____

Do you have a history of abnormal Pap Smear? YES NO

Please describe: _____

_____

OFFICE POLICIES ACKNOWLEDGEMENT

Greenhouse Integrative Medicine, LLC and its staff are dedicated to providing you with the best possible healthcare services. We have adopted the following office policies in order to minimize confusion or misunderstanding between our patients and our healthcare practice. Please read the following policies carefully. Should you have any questions or concerns, feel free to ask one of our staff members for assistance.

Participating Insurance, Assignment of Benefits, Authorization, and Notice of Collection Action

I understand that I am responsible for knowing the benefits my insurance policy provides. I am also responsible for knowing the requirements and coverage limitations of my insurance policy. It is also my responsibility to verify proof of insurance by ensuring that Greenhouse Integrative Medicine, LLC has the most current/valid insurance card on file. I further understand that all co-payments are due at the time of service and that I am also responsible to pay other amounts due, if applicable. Such amounts may include annual deductibles, charges denied by my insurance company (as not covered or not medically necessary), and/or any fees incurred should my account require collection action (such as late fees, collection agency fees, court costs, or attorneys' fees). Also, I have been advised that Greenhouse Integrative Medicine, LLC may contact me via an automated system regarding appointments and/or account status. I agree that this authorization shall remain in effect unless/until I rescind such authorization in writing.

Referral Requirements

If a referral is required by my insurance provider, I must present the referral to Greenhouse Integrative Medicine, LLC prior to receiving services. I must ensure that the referral is made to the correct doctor, that it has not expired, and that the number of allowable visits has not expired. If I receive services without obtaining a required referral, I acknowledge and accept that I will be financially responsible for such services.

Use of Photograph

I agree that my patient photographs taken in connection with medical treatment (including medical cannabis treatment) will be considered a part of my patient record and may be used by my health care provider solely for the purpose of patient identification.

Self-Paying Patients

Payments for services are due when services are rendered. If Greenhouse Integrative Medicine, LLC does not participate in my insurance policy, it is my understanding that Greenhouse Integrative Medicine, LLC will assist me with processing my insurance claim, and/or providing me with an itemized bill, once all fees have been paid in full.

Acknowledgement

I have read and fully understand the policies above regarding insurance, payments, referral requirements, and the use of my photographs. I agree to pay for services not covered by my insurance policy, if I have not obtained and presented a valid referral at the time services are rendered. I agree to pay for services and tests not covered by my insurance policy.

Patient Full Name: _____ **Date:** _____

Signature of Patient: _____

Signature of Parent/Legal Guardian: _____

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Authorization for Use and Disclosure of Protected Health Information ("PHI")

I authorize the use and disclosure of all health information for the purpose of treatment, payment, and health care operations. I authorize Greenhouse Integrative Medicine, LLC and its staff to use such disclosures of my health information without limitation. I understand that information disclosed pursuant to this authorization may be further disclosed to additional parties. Such disclosures effectively withdraw protections to my protected health information. I understand that any revocation of this authorization does not apply to disclosures or use of PHI that have occurred prior to my revocation. In addition, I authorize disclosure of my PHI to the following individual(s):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

List any person(s) that you are allowing this office to communicate with regarding your PHI

Patient Method of Contact

In general the HIPAA Privacy rule gives individual patients the right to request a restriction on uses and disclosures of their PHI. I understand that a verbal request is an acceptable authorization for the use of any alternate contact method, contact number, and/or contact location as well as to change the method of contact listed below (i.e. if the patient leaves a message with a contact number and/or contact location, other than the method listed below). I understand that Greenhouse Integrative Medicine, LLC may call me to confirm my appointments at the number provided below.

**** I Wish To Be Contacted By The Following Method**

_____ NO RESTRICTION (Home Phone, Work Phone, or Cell Phone)

_____ Restricted Method of Contact (Check all that apply)

_____ Home Phone ONLY, leave a message for a return call to the medical practice

_____ Work Phone ONLY, leave a message for a return call to the medical practice

_____ Cell Phone ONLY, leave a message for a return call to the medical practice

_____ Other Method of Contact: _____

I acknowledge and understand that by signing this form I am confirming my receipt of the Notice, the authorization for method of contact, and the authorization for use and/or disclosure of my PHI.

Patient Full Name: _____ **Date:** _____

Signature of Patient: _____

Signature of Parent/Legal Guardian: _____

HIPAA Notice of Privacy Practices Acknowledgment Form

I acknowledge that I have received the HIPAA Notice of Privacy Practices (the "Notice") from Greenhouse Integrative Medicine, LLC and that I have been provided an opportunity to review it. I understand that:

- I have certain rights to privacy regarding my protected health information (PHI)
- Greenhouse Integrative Medicine, LLC can and will use my health information for purposes of my treatment, payment for treatment, and health care operations
- The Notice explains in more detail how Greenhouse Integrative Medicine, LLC may use and share my PHI for other purposes
- I have the rights regarding my PHI listed in the Notice
- Greenhouse Integrative Medicine, LLC has the right to change the Notice from time to time, and I can obtain a current copy of the Notice by contacting the person listed in the Notice

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgment Form

Name of Patient: _____ Date of Birth: _____

I attempted to obtain the patient's (or the patient's representative's) signature on the **HIPAA Notice of Privacy Practices Acknowledgment Form**, but was unable to do so as documented below:

Reason:_____

Name: _____ Date: _____

Signature: _____