Belvonae Health & Wellness
EMAIL: info@belvonae-hw.com
PHONE: 301-416-9971

NEW PATIENT INTAKE FORM

Name: _____ Date: _____

Street Address: _____

Phone: _____ Home Phone: _____

Email: _____ Birth Date: _____

Sex: ☐ M ☐ F Birth Gender: ☐ M ☐ F Height: Weight: _____

Race: Hispanic or Latino: ☐ Yes ☐ No _____

Marital Status: _____

Occupation: How did you hear about us? _____

Primary Care Physician: Phone: _____

Emergency Contact: Phone: Relationship: _____

NEW PATIENT INTAKE FORM

Check **ALL medical conditions** that you may have had or currently have now:

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergy
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Breathing
- ☐ problems
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Chronic Fatigue
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Fibromyalgia
- ☐ Gall Bladder
- ☐ Goiter
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Vertigo/Dizziness
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Blood Sugar
- ☐ HIVIAIDS
- ☐ Irritable Bowel
- ☐ Kidney Infect./stones
- ☐ Low Blood Pressure
- ☐ Low Blood Sugar
- ☐ Lyme Disease
- ☐ Lupus
- ☐ Leg swelling
- ☐ Migraine
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Raynaud's
- ☐ Rheumatoid Arthritis
- ☐ Ringing in ears
- ☐ Self Injury
- ☐ Sinus Infection
- ☐ Stroke
- ☐ Suicidal Ideation
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Visual disterbance

Other: _____

Please list all previous surgeries & dates:

_____

_____

Alcohol use? ___Yes / ___ No Amount _____ Daily / Weekly / Socially

Tobacco use? ___ Yes / ___ Never / Former Smoker PPD _____ How many years? _____

NEW PATIENT INTAKE FORM

List **ALL** medications & supplements you take (prescription & over the counter)

Please list all medications, over the counter drugs, and herbal supplements you are currently taking. Please include any prescription topical creams and hormone replacement therapy medications/implants.

Medication and Supplement	*Frequency*	*Dose*	*Purpose/Prescribed For*

Allergies & Sensitivities

Do you have any allergies or sensitivities to foods, medications, implants, etc? ☐ Yes ☐ No

If yes, please list all allergens and how you react to them:

_____

_____

NEW PATIENT INTAKE FORM

AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes_____ No_____

I fully understand that my signature is consent and authorization to be examined by Belvonae Health & Wellness Medical Team.

I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Patient Signature _____ Date _____

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that if you must cancel your appointment you provide a 24 hour notice. Appointments which are cancelled within less than 24 hour notice may be subject to pay the full balance owed at the time of cancellation. Cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.
We understand that unavoidable circumstances may cause you to cancel with less than a 24-hour notice, fees may be waived upon management approval.
Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no show fees can be directed to the front desk at (301)-416-7791.

Please sign that you have read, understand and agree to this cancellation and no-show policy.

I affirm the information I have provided regarding my health history, medication record, and prior surgeries and aesthetic treatments is accurate to the best of my knowledge. I acknowledge that Belvonae Health & Wellness Staff are not responsible for any errors that may occur as a result of any omissions or incorrect information on this form.

_____

Patient Name (Please Print) Date

_____

Signature of Patient **Date**