ACHIEVE HEALTH

PATIENT INTAKE FORM

NAME: _____ DATE: _____

DATE OF BIRTH: _____ GENDER: _____

SOCIAL SECURITY : _____ ETHNICITY:_____

ADDRESS:_____

CITY: _____ STATE: ____ ZIP:_____

EMAIL ADDRESS:_____

HOME PHONE: _____ CELL: _____

REFERRED BY :

_____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____

CELL PHONE: _____ WORK PHONE: _____

PHARMACY INFORMATION:

NAME: _____ ADDRESS: _____

PHONE: _____

INSURANCE INFORMATION:

INSURANCE COMPANY: _____ PHONE#: _____

ID# _____ GROUP# _____

INSURED NAME: _____ RELATIONSHIP: _____

I understand that Ryan Nolen, DO/ Achieve Health does not participate in insurance plans and payment is due at time of service. I authorize any holder of medical information about me to release to my insurance company any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to paid to myself.

I understand that 24 hours notice is required prior to cancelling an appointment. Same day cancellations may result in a partial visit charge.

SIGNATURE: _____ DATE: _____

ACHIEVE HEALTH

PATIENT INFORMATION

NAME: _____ DATE: _____

DOB: _____ GENDER: _____

ALLERGIES:

_____

LIST ALL MEDICATIONS: (Prescriptions, over-the–counter, and vitamin supplements)

MEDICATION	DOSAGE	WHEN DO YOU TAKE IT
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PERSONAL MEDICAL HISTORY: (Circle all that apply to you or family members.)

ADHD	COPD/ Emphysema	Kidney Disease	Psoriasis
Alcoholism	Dementia	High Cholesterol	Seizures
Anemia	Depression	HIV	Sleep Apnea
Anxiety	Diabetes: 1 or 2	Hepatitis	Stroke
Arrhythmia	Diverticulitis	Irritable Bowel	Thyroid
Arthritis/Rheumatoid	DVT (blood clot)	Lupus	
Asthma	GERD (acid reflux)	Liver Disease	
Bipolar	Glaucoma	Macular Degeneration	
Bladder problems	Heart Disease	Neuropathy	
Urinary Tract Infections	Heart Attack	Orthopedic Issues	
Bleeding problems	Hiatal Hernia	Parkinson's Disease	
Cancer	High Blood Pressure	Stomach Issues	
Crohn's Disease	Kidney Stones	Pulmonary Embolism	
Colitis			

MEDICAL ISSUES NOT LISTED ABOVE:

_____

SURGICAL HISTORY: (Provide approximate dates.)

Surgery:	Date:
_____	_____
_____	_____
_____	_____

SOCIAL/ CULTURAL HISTORY:

Marital Status: (Circle)

Single Married Divorced Widowed

Highest Education Level: (Circle)

Elementary High School Vocational College Master's/ Doctorate

Profession or Current Job:

_____

Current Living Situation: (Circle all that apply):

Single Family Home Multi Family Home Homeless Shelter

Skilled Nursing Facility Senior Living With Children Other

Smoking/ Tobacco Use: (Circle all that apply)

Current Past Never

Type: _____ Amount: _____ Number of years: _____

Alcohol: (Circle all that apply)

Current Past Never Number/week: _____

Recreational Drug Use: (Circle all that apply)

Current Past Never

Type: _____

Are You Sexually Active: (Circle)

Yes No

FAMILY HISTORY: (Circle all that apply)

FATHER: Living Age: _____ Deceased Age: _____

Alcoholism	Cancer: _____	DVT (Blood Clot)	Migraines
Anemia	COPD/ Emphysema	Heart Disease	Osteoporosis
Asthma	Dementia	High Blood Pressure	Stroke
Arthritis	Depression	High Cholesterol	Thyroid
Bipolar	Diabetes: I or II	Kidney Disease	

Other: _____

MOTHER: Living Age: _____ Deceased Age: _____

Alcoholism	Cancer: _____	DVT (Blood Clot)	Migraines
Anemia	COPD/ Emphysema	Heart Disease	Osteoporosis
Asthma	Dementia	High Blood Pressure	Stroke
Arthritis	Depression	High Cholesterol	Thyroid
Bipolar	Diabetes: I or II	Kidney Disease	

Other: _____

SIBLINGS: (List any significant medical problems of brothers or sisters)

_____

_____

List any other Medical Providers that you see on a REGULAR basis:

(Cardiologist, Mental Health Provider, Kidney Doctor, Dentist)

SIGNATURE: _____ DATE: _____

ACHIEVE HEALTH

FINANCIAL RESPONSIBILITY FORM

DEAR PATIENT,

Please be advised that we are asking every patient to provide us with current credit card information at the time of service.

We require payment to be made in full at the time of service, but should any outstanding balance remain on your account for longer than 30 days, the credit card information that you have provided to us will be used to collect these outstanding fees.

Thank you for your cooperation.

Patient Name PRINTED:

_____

Patient Signature:

_____

Date:

_____

ACHIEVE HEALTH

CREDIT CARD SIGNATURE ON FILE FORM

In order to simplify your payment responsibilities, Ryan Nolen, DO enables you to make your payments by credit card. To facilitate processing and to permit you to authorize payments via phone, Ryan Nolen, DO requests that you sign below so that we can maintain a signature on file.

I, the undersigned acknowledge that Ryan Nolen, DO is hereby authorized to charge my credit card for payments authorized by me without obtaining additional signatures.

Patient Name PRINTED:

_____

Patient Signature: _____

Date: _____

Credit Card Type (circle one):

Mastercard Visa

Credit Card Expiration: _____

Credit Card Number: _____

Security Code: _____