ACHIEVE HEALTH

RYAN NOLEN, DO

PATIENT INTAKE FORM

- How did you find out about Achieve Health? _____

PERSONAL INFORMATION

NAME: _____ REFERRED BY: _____

ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____

STATE/ ZIP _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

EMAIL: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

CELL PHONE: _____ WORK PHONE: _____

CASH PAY: YES_____ NO_____

PRIMARY MEDICAL INSURANCE **SECONDARY MEDICAL INSURANCE**

Ins. Co. Name:	Ins. Co. Name:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's SS#	Policy Holder's SS#
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

PHARMACY INFORMATION

NAME: _____ ADDRESS: _____

PHONE: _____ ZIP CODE: _____

ALLERGIES

Do You Have ANY Drug Allergies? (Please Circle One) YES NO

If YES, Please List the Name of the Medication and Your Reaction to That Medication

1. _____ REACTION: _____
2. _____ REACTION: _____
3. _____ REACTION: _____
4. _____ REACTION: _____

MEDICATIONS

Please List ALL Prescriptions, Over- the –Counter, Vitamins, and Herbal Supplements Below

	Medication	Dosage	Time Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

PAST MEDICAL HISTORY [Circle All That Apply]

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

SURGICAL HISTORY

Date:	Type of Surgery:
_____	_____
_____	_____
_____	_____

FAMILY HISTORY. **[Circle All That Apply]**

FATHER: Living Age: _____ Deceased Age: _____

Alcoholism	Bipolar	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes: 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/ Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid
Arthritis	Dementia	Heart Disease	Migraines	

OTHER: _____

MOTHER: Living Age: _____ Deceased Age: _____

Alcoholism	Bipolar	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes: 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/ Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid
Arthritis	Dementia	Heart Disease	Migraines	

OTHER: _____

SIBLINGS: (List any significant problems with your brothers or sisters)

PREVENTIVE CARE

Last Physical	**Date:**	**Last Colon Cancer Screen**	**Date:**
Last Pap Smear	**Date:**	**Last Bone Density**	**Date:**
Last Mammogram	**Date:**	**Last Stress Test**	**Date:**

SOCIAL. HISTORY

Marital Status (Circle): Single Married Divorced Widowed

Education Level: (Circle the Highest Completed)

High School Vocational College Masters/ Doctorate

Profession/ Trade: _____

Smoking/ Tobacco Use: (Circle) Current Past Never

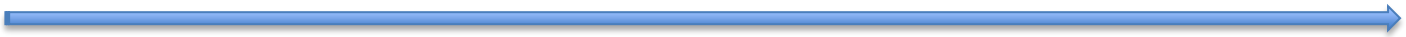
Type: _____ Amount: _____ Number of Years: _____

Alcohol: (Circle) Current Past Never

Recreational Drug Use: (Circle) Current Past Never

Type: _____

Sexually Active: (Circle) No Yes



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

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

_____

_____

Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY FORM

Patient Name: _____. DOB: _____

We accept Visa, Mastercard, Health Savings Account Cards, and Cash

We require payment to be made in full at the time of service, but should any outstanding balance remain on your account, the credit card information that you have provided to us will be used to collect these outstanding fees (see *Credit Card on File Form below).*

We ask that in the event that you are unable to keep your scheduled appointment, you please give us at least a 24- hour notice. Appointments that are not kept or adequate notice is not given are inconsiderate to our physician/ staff and it is time that could have been given to another patient. There are emergencies and we understand this, but a "No Show" without calling to reschedule or cancel will be charged a $50 fee.

Due to increasing healthcare costs, we will charge a fee for requested documents. Such documents include: medical forms to be filled out by the physician, disability forms from your employer, and copies of your medical records.

Thank you for your cooperation.

Signature: _____

Print Name: _____

Date: _____

Communication of PIH (Personal Health Information)

CONSENT TO RECEIVE ELECTRONIC COMMUNICATION FROM DR. NOLEN AND HIS STAFF

I agree that Dr. Nolen and his staff may communicate with me about my personal health information, scheduling, billing or other important issues regarding my care, via the following electronic means:

(Please **CIRCLE** all that apply)

Email Cell/ Home Phone Personal Fax

Leave a message on my Cell/ Home Phone

Please list below any person(s) that Dr. Nolen or his staff may contact to discuss any information related to your billing account and/or medical conditions.

1. _____ _____ _____

Name Relationship Phone Number

( ) Billing Account Information ( ) Medical Condition Information

2. _____ _____ _____

Name Relationship Phone Number

( ) Billing Account Information ( ) Medical Condition Information

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

_____ _____

Name of Legal Guardian Relationship

Authorization for Disclosure of Medical Records
To Dr. Nolen/ Achieve Health

Patient Name _____

Previous Name: _____

Address: _____

Date of Birth _____

Authorizes the release of all medical records: including radiology films, pathology, laboratory results

FROM: Name of Physician/ Facility _____

Address: _____

Phone: _____

FAX: _____

TO: Achieve Health Physician Services

Dr. Ryan Nolen

2921 Brown Trail, Suite 135

Bedford, TX 76021

FAX: 817- 398- 4029

Patient Signature _____

Date _____

CONSENT FOR TREATMENT

I, knowing that I am/ may be suffering from a condition requiring diagnostic or medical treatment, do hereby voluntarily consent to such medical care under the general and specific instructions of Dr. Nolen and/or his assistants.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of the treatments or examination by Dr. Nolen.

_____ _____

Signature of Patient Date Signed

_____ _____

Legal Guardian Date Signed

_____

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative)

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: _____

Patient Signature: _____

Date: _____

Credit Card: ***Circle One*** ***MASTERCARD*** ***VISA***

Credit Card Number: _____

Expiration Date: _____

3 Digit Security Code (Back of Card) : _____