Patient Intake Form 2023

Print clearly. Complete all information.

Patient Information

LAST NAME	FIRST NAME	MIDDLE INITIAL
EMAIL ADDRESS		
SOCIAL SECURITY # (IF YOU HAVE ONE)	DATE OF BIRTH	
STREET ADDRESS	CITY, STATE	
ZIP CODE	PHONE (HOME)	PHONE (CELL)
SEX (AT BIRTH) ☐ MALE ☐ FEMALE	PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ ARABIC ☐ OTHER _____	

Look for the number of persons in your family/household in the first column. Check the box in the income column that best describes your situation.

FAMILY SIZE	LESS THAN OR EQUAL TO	LESS THAN OR EQUAL TO	LESS THAN OR EQUAL TO	LESS THAN OR EQUAL TO	LESS THAN OR EQUAL TO	EQUAL TO OR OVER
1	☐ $14,580	☐ $18,255	☐ $21,870	☐ $25,515	☐ $29,160	☐ $29,161
2	☐ $19,720	☐ $24,650	☐ $29,580	☐ $34,510	☐ $39,440	☐ $39,441
3	☐ $24,860	☐ $31,075	☐ $37,290	☐ $43,505	☐ $49,720	☐ $49,721
4	☐ $30,000	☐ $37,500	☐ $45,000	☐ $52,500	☐ $60,000	☐ $60,001
5	☐ $35,140	☐ $43,925	☐ $52,710	☐ $61,495	☐ $70,280	☐ $70,281
6	☐ $40,280	☐ $50,350	☐ $60,420	☐ $70,490	☐ $80,560	☐ $80,561
7	☐ $45,420	☐ $56,775	☐ $68,130	☐ $79,485	☐ $90,840	☐ $90,841
8	☐ $50,560	☐ $63,200	☐ $75,840	☐ $88,480	☐ $101,120	☐ $101,121

Emergency Contact Information

LAST NAME	FIRST NAME	
RELATIONSHIP	STREET ADDRESS	
CITY, STATE	ZIP CODE	PHONE (CELL)
PHONE (HOME)	PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ ARABIC ☐ OTHER _____	

Patient Intake Form 2023

PATIENT NAME _____ DATE OF BIRTH _____

If you don't have insurance, you can ask us for an estimate of your costs before you get care. Our staff will work with their manager to get you this estimate.

Insurance Information/Policy Holder Information

Primary Insurance Information

WHO IS THE POLICY HOLDER? ☐ PARENT/ GUARDIAN ☐ SPOUSE ☐ SELF ☐ OTHER _____	
INSURANCE COMPANY NAME	
INSURANCE COMPANY STREET ADDRESS	INSURANCE COMPANY CITY, STATE
INSURANCE COMPANY ZIP CODE	

Primary Insurance Policy Holder Information

POLICY HOLDER LAST NAME		POLICY HOLDER FIRST NAME
POLICY HOLDER MIDDLE INITIAL	SUFFIX ☐ JR. ☐ SR. ☐ OTHER _____	DATE OF BIRTH
POLICY HOLDER PHONE NUMBER		POLICY HOLDER STREET ADDRESS
POLICY HOLDER CITY, STATE		POLICY HOLDER ZIP CODE
POLICY ID #		GROUP/PLAN #

Secondary Insurance Policy Holder Information

POLICY HOLDER LAST NAME		POLICY HOLDER FIRST NAME
POLICY HOLDER MIDDLE INITIAL	SUFFIX ☐ JR. ☐ SR. ☐ OTHER _____	DATE OF BIRTH
POLICY HOLDER PHONE NUMBER		POLICY HOLDER STREET ADDRESS
POLICY HOLDER CITY, STATE		POLICY HOLDER ZIP CODE
POLICY ID #		GROUP/PLAN #

FOR OFFICE USE ONLY ☐ DOCUMENTS REVIEWED ☐ PAY STUB ☐ TAX STATEMENT ☐ W2 ☐ LETTER OF SUPPORT ☐ _____

Patient Intake Form 2023

PATIENT NAME _____ DATE OF BIRTH _____

Patient Background

Race

- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN
- ☐ OTHER PACIFIC ISLANDER
- ☐ TWO OR MORE
- ☐ WHITE (CAUCASIAN)
- ☐ UNREPORTED/ REFUSED TO REPORT

Ethnicity

- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO

Place of Birth

- ☐ UNITED STATES
- ☐ OTHER, PLEASE SPECIFY _____

Gender Identity

- ☐ FEMALE
- ☐ MALE
- ☐ NEITHER EXCLUSIVELY MALE NOR FEMALE
- ☐ TRANSGENDER FEMALE-TO-MALE
- ☐ TRANSGENDER MALE-TO-FEMALE
- ☐ DECLINE TO ANSWER
- ☐ OTHER _____

Sexual Orientation

- ☐ BISEXUAL
- ☐ LESBIAN, GAY
- ☐ SOMETHING ELSE
- ☐ STRAIGHT (NOT LESBIAN OR GAY)
- ☐ DON'T KNOW
- ☐ DECLINE TO ANSWER

Housing Status

ARE YOU HOMELESS? ☐ YES ☐ NO	ARE YOU A VETERAN? ☐ YES ☐ NO
IF YES: ☐ SHELTER ☐ STREET ☐ DOUBLING UP ☐ TRANSITIONAL HOUSING	

Programs

DO YOU CURRENTLY GET FOOD STAMPS? ☐ YES ☐ NO	DO YOU CURRENTLY GET WIC? ☐ YES ☐ NO	DO YOU NEED HELP PAYING FOR YOUR MEDICINE? ☐ YES ☐ NO

Food Pharmacy

DO YOU WANT A FOOD BOX TODAY? ☐ YES ☐ NO

Healthy Literacy

Please check your response to the questions below:

A. HOW OFTEN DO YOU HAVE SOMEONE HELP YOU READ MEDICAL MATERIALS?	☐ ALWAYS	☐ OFTEN	☐ SOMETIMES	☐ OCCASIONALLY	☐ NEVER
B. HOW OFTEN DO YOU HAVE A PROBLEM UNDERSTANDING WHAT IS TOLD TO YOU ABOUT YOUR MEDICAL CONDITION?	☐ ALWAYS	☐ OFTEN	☐ SOMETIMES	☐ OCCASIONALLY	☐ NEVER

How Did You Hear About Us?

- ☐ FRIEND/FAMILY
- ☐ OUR STAFF
- ☐ GOOGLE
- ☐ FACEBOOK
- ☐ TWITTER
- ☐ OUR WEBSITE
- ☐ ADVERTISEMENT (POSTCARD, NEWSPAPER, ETC.)
- ☐ I SAW THE CLINIC
- ☐ COMMUNITY EVENT
- ☐ OTHER _____

Patient Intake Form 2023

PATIENT NAME _____ DATE OF BIRTH _____

About You

Tell us about your background. This helps us provide the best possible care. We will protect your privacy. We treat your information as confidential.

Allergies

HAVE YOU EVER HAD AN ALLERGIC REACTION? ☐ YES ☐ NO	MEDICATION ALLERGIES
FOOD ALLERGIES	OTHER ALLERGIES (LATEX, BEE STINGS, ETC.)

Pharmacy Information

PHARMACY NAME	PHONE NUMBER
ADDRESS/LOCATION	

Dental

ARE YOU CURRENTLY HAVING PROBLEMS WITH DENTAL PAIN? ☐ YES ☐ NO	DO YO JR GUMS EVER BLEED? ☐ YES ☐ NO
HAVE YOU EVER TAKEN ANTIBIOTIC PREMEDICATION TREATMENT? ☐ YES ☐ NO	

Family History

☐ BIRTH FAMILY HISTORY UNKNOWN

Does your family have any of the following?	MOTHER	FATHER	SIBLINGS	GRANDPARENTS
ALCOHOLISM	☐	☐	☐	☐
CANCER (WHAT TYPE?)	☐ _____	☐ _____	☐ _____	☐ _____
DIABETES	☐	☐	☐	☐
DRUG DEPENDENCY	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐
STROKE				
SUDDEN CARDIAC ARREST (UNDER AGE 50)				
OTHER (PLEASE EXPLAIN)	☐ _____	☐ _____	☐ _____	☐ _____
DECEASED	☐	☐	☐	☐

Patient Intake Form 2023

PATIENT NAME _____ DATE OF BIRTH _____

Your Medical History

DO YOU HAVE or HAVE YOU EVER HAD?

- ☐ ADHD
- ☐ ADRENAL DISORDERS
- ☐ ALCOHOL ABUSE
- ☐ ANEMIA
- ☐ ANOREXIA (EATING DISORDER)
- ☐ ANXIETY DISORDER
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BIPOLAR DISORDER
- ☐ BLEEDING DISORDERS
- ☐ BLOOD CLOTS/CLOTTING DISORDERS
- ☐ BULIMIA (EATING DISORDER)
- ☐ CANCER
- ☐ CELIAC DISEASE
- ☐ CHICKENPOX/VARICELLA
- ☐ CHLAMYDIA
- ☐ CHRONIC KIDNEY OR BLADDER DISEASE
- ☐ CHRONIC SINUS INFECTIONS
- ☐ CONCUSSIONS
- ☐ CONVULSIONS/SEIZURES
- ☐ COPD
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ ECZEMA
- ☐ EYES DISORDERS (OTHER THAN GLASSES OR CONTACTS)
- ☐ FRACTURES/BROKEN BONES
- ☐ GENITAL HERPES
- ☐ GENITAL WARTS
- ☐ GONORRHEA
- ☐ HEARING LOSS
- ☐ HEART DISEASE/HEART ATTACK
- ☐ HEART MURMUR
- ☐ HEPATITIS TYPE: _____
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV INFECTION
- ☐ HIVES
- ☐ HPV
- ☐ KIDNEY STONES
- ☐ LUPUS
- ☐ MALARIA
- ☐ MIGRAINES/SEVERE HEADACHES
- ☐ MULTIPLE SCLEROSIS
- ☐ MUMPS
- ☐ MUSCULAR DYSTROPHY
- ☐ NASAL ALLERGIES/HAY FEVER
- ☐ OTHER BONE OR JOINT PROBLEMS

_____

- ☐ OTHER LIVER, STOMACH OR BOWEL DISEASES

_____

- ☐ OTHER MENTAL HEALTH PROBLEMS

_____

- ☐ OTHER NEUROLOGICAL PROBLEMS

_____

- ☐ OTHER STD
- ☐ INCONTINENCE
- ☐ INFECTIOUS MONONUCLEOSIS
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ PNEUMONIA
- ☐ POLYCYSTIC OVARY SYNDROME (PCOS)
- ☐ PSORIASIS
- ☐ RADIATION THERAPY
- ☐ SCHIZOPHRENIA
- ☐ STOMACH/DUODENAL ULCERS
- ☐ STROKE/TIA
- ☐ SYPHILIS
- ☐ THYROID DISORDER
- ☐ TUBERCULOSIS
- ☐ TYPHOID FEVER
- ☐ ULCERATIVE COLITIS/CROHN'S

OB/GYN History

LAST MENSTRUAL PERIOD DATE

_____

DATE OF LAST PAP SMEAR

_____

HISTORY OF ABNORMAL PAP SMEAR?

☐ YES ☐ NO

DATE OF LAST BREAST EXAM

_____

HISTORY OF ABNORMAL BREAST EXAM?

☐ YES ☐ NO

NUMBER OF TOTAL PREGNANCIES

_____

NUMBER OF CHILDREN DELIVERED

_____

ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING?

☐ YES ☐ NO

Activity Level

Would you say your activity level is:

- ☐ LITTLE EXERCISE: Seated most of the day; desk job; little activity.

  For example, walking for 10-15 minutes 1-2 times a week.

- ☐ SOME EXERCISE: Activity that raises your heart rate and makes you sweat.

  For example, walking briskly 30 minutes a day, 5 days a week.

- ☐ A LOT OF EXERCISE: Activity that makes raises your heart rate and makes you breathe hard and fast.

  For example, jogging or running for 1 hour and 15 minutes, every week.

Substance Use

- ☐ DO YOU DRINK ALCOHOL?
- ☐ DO YOU SMOKE?
- ☐ DO YOU TAKE RECREATIONAL DRUGS?
- ☐ DO YOU VAPE?

Patient Intake Form 2023

PATIENT NAME _____ DATE OF BIRTH _____

Your Medical History

Please check any of the following YOU have ever had or are currently experiencing

Surgical History

- ☐ APPENDECTOMY
- ☐ ADENOIDECTOMY
- ☐ COLON SURGERY
- ☐ EAR TUBES
- ☐ GALLBLADDER REMOVAL
- ☐ HIP SURGERY
  - ○ LEFT ○ RIGHT
- ☐ KNEE SURGERY
  - ○ LEFT ○ RIGHT
- ☐ HYSTERECTOMY
- ☐ ORGAN TRANSPLANT
- ☐ OVARIAN CYST REMOVAL
- ☐ PROSTATE SURGERY
- ☐ SPLENECTOMY
- ☐ TONSILLECTOMY
- ☐ WEIGHT LOSS SURGERY
- ☐ OTHER PRIOR SURGERIES

_____

_____

Other History

☐

Previous Hospitalizations/ER Visits

_____

_____

_____

Please list all current medications you take. Include prescriptions, birth control, acne, over the counter medications, vitamins, etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Consent Form

PATIENT NAME _____ **DATE OF BIRTH** _____

	Summary	Full Details
Initial _____ Here	**I want to get the care that Salvus Center and Neighborhood Health recommends for me.* It is okay for Salvus Center and Neighborhood Health to treat me.*** ***or a minor child, if a minor child is the patient and I am the parent or legal guardian and I can authorize treatment.**	I consent to the evaluation and treatment as may be deemed necessary or advisable in the judgment of a Salvus Center and Neighborhood Health physician or another clinical provider. This may include but not limited to an interview, physical examination, laboratory studies, or other services rendered the patient under the general and special instructions of the provider.
Initial _____ Here	**I agree the insurance company, Medicare, TennCare, or other programs can pay my bill. I allow Salvus Center and Neighborhood Health to keep these payments.**	In consideration of services rendered, I hereby transfer and assign to NH all rights, title, and interest in any payment due to me (or my child) for services described herein as provided in the above-mentioned policy or policies of insurance. Salvus Center and Neighborhood Health may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient) for all or part of the clinic's charge, including but not limited to medical and dental service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer. I hereby agree that all Medicaid/Medicare payments pertaining to my treatment (or that of my child) shall be assigned to Salvus Center and Neighborhood Health.
Initial _____ Here	**I agree to pay the fees I owe that are not covered by insurance, Medicare, TennCare, or other programs.**	I agree, in consideration of the services to be rendered to me (or my child), I am obligated to pay applicable fees based on my household income and family size. I understand Salvus Center and Neighborhood Health may file insurance claims as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. I also understand I must pay any co-pay, deductible, co-insurance, or any other balance not paid for by my insurance or third-party payer (or that of my child) within a reasonable period of time not to exceed ninety (90) days.
Initial _____ Here	**Salvus Center and Neighborhood Health can contact me by phone, email, and text.**	I give my permission for Salvus Center and Neighborhood Health to contact me by phone, email, and text regarding appointments, lab results, billing, and announcements. I know I can opt out by telling Salvus Center and Neighborhood Health I do not want to get messages in a particular form or way.
Initial _____ Here	**Salvus Center and Neighborhood Health offered me a notice about privacy. Salvus Center and Neighborhood Health also offered me notice about my rights as a patient.**	I have been offered (a) a copy of the Salvus Center and Neighborhood Health's HIPAA Notice of Privacy Practices; and (b) Salvus Center and Neighborhood Health's Health Patient Rights and Responsibilities. I also know Salvus Center and Neighborhood Health will email or mail me a copy if I ask.
Initial _____ Here	**I know Salvus Center and Neighborhood Health will keep a copy of this.**	I authorize Salvus Center and Neighborhood Health to use a copy of these authorizations and assignments. Salvus Center and Neighborhood Health will file any hard copy original. Your authorization remains valid unless and until you revoke it in writing.
Initial _____ Here	**I know everyone is welcome at Salvus Center and Neighborhood Health.**	If I have been discriminated against based on race, color, or national origin, I know I can file a "Title VI" complaint with Salvus Center and Neighborhood Health by calling 615-227-3000 x1007. I can also file a complaint with the regional or central office of the Department of Mental Health and Substance Abuse Services or the Office of Civil Rights, 101 Marietta Tower, Suite 2706, Atlanta, GA.

I know Salvus Center and Neighborhood Health will use the information on this form when providing care to me and

my family. All of the information I put on this form is true and accurate.

SIGNATURE: X_____ **DATE:** _____