



Patient Information Forms

[] New Patient [] Updating Information

Patient Full Legal Name: _____ Goes By: _____

Date of Birth: ____/____/____ SSN: ____-____-____ Gender: _____

Preferred Language: [] English [] Spanish [] Other: _____ Race: _____

Ethnicity: [] Not Hispanic or Latino [] Hispanic or Latino [] Other: _____

Address: _____

Phone Number: (____) _____ - _____ Home/Work/Cell Phone Number: (____) _____ - _____ Home/Work/Cell

Email Address: _____ Are you interested in our patient portal? [] Yes [] No

Employer: _____ Occupation: _____

Marital Status: [] Single [] Married [] Separated [] Divorced

Emergency Contact Name: _____ Relationship: _____ Phone: (____) _____ - _____

Financial Responsibility: I will be financially responsible for any and all charges for services rendered at Authentic Health that are not paid by my insurance company. I agree that I will make full payment for my visit today depending on what my insurance policy requires. It is my responsibility, and not the responsibility of Authentic Health to know if my insurance will pay for my office visit or medical services. It is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation. It is my responsibility to know if the provider I am seeing is a contracted in-network provider recognized by my insurance company. It is also my responsibility to know if my choice of primary care physician has been processed by my insurance company. Initial: _____

48 Hour Appointment Cancellation Policy: I acknowledge that Authentic Health has a 48 hour cancellation / rescheduling policy. If I miss my appointment, cancel, or change your appointment less than 48 hours from my appointment, I will be charged \$45.00. This policy is in place out of respect for our providers and other patients. Cancellations with less than 48 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to use the open time slot. Initial: _____

Ancillary Services: Your physician may refer you to one or more "ancillary services" which is a service relating to your medical care or treatment. Ancillary services may include, but are not limited to, MRI, CT scan, x-ray, or audiology testing. You are not obligated to use the provider/facility that your physician refers to you to. You are free to choose the provider/facility of your choice. I understand that I may receive a separate bill if my medical care includes labs, radiology, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason. Initial: _____

Assignment of Insurance Benefits: I hereby authorize direct payment of my insurance benefits to Authentic Health PLLC or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Authentic Health, PLLC is unable to collect from my insurance carrier for whatever reason. Initial: _____

Medicare/Medicaid/CHAMPUS Insurance Benefits: I certify that that information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to Authentic Health, PLLC or the physician on my behalf. Initial: _____

Authorization to Release Non-Public Personal Information: I certify that I have been offered and read a copy of the "HIPAA Notice of Privacy Practices". I hereby authorize Authentic Health, PLLC or the physician individually to release any of my, or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. **Initial:** _____

Authorization to Mail, Call, Text, or E-Mail: I certify that I understand the privacy risks of mail, phone calls, texts, or emails. I hereby authorize the staff of Authentic Health, PLLC to mail, call, text, or email me in regards to my healthcare, including but not limited to, appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Authentic Health, PLLC of this change in writing. **Initial:** _____

Collections: Authentic Health partners with Professional Recovery Consultants for any outstanding claims. Claims will be turned over to PRC if a bill has not been paid within 90 days from the date of service and no payment arrangements have been made with the Authentic Health billing department. I agree in order for Authentic Health, PLLC and Professional Recovery Consultants to be able to service my account or collect any amounts I may owe, that I may be contacted by telephone at any telephone number associated with my account, including wireless numbers, which could result in charges from my wireless carrier. Methods of contact may include re-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. **Initial:** _____

HIPAA Information Release: IN ORDER TO PROTECT YOUR PATIENT CONFIDENTIALITY, WE NEED TO KNOW IF THERE IS A PHONE NUMBER (WITH VOICEMAIL) FOR YOU WHERE WE LEAVE RESULTS OF YOUR LABORATORY TESTS OR OTHER SENSITIVE INFORMATION. BY INDICATING THE INFORMATION BELOW, I GIVE AUTHENTIC HEALTH EMPLOYEES PERMISSION TO LEAVE CONFIDENTIAL HEALTH CARE INFORMATION FOR ME AT THE FOLLOWING PHONE NUMBER(S):

Phone Number: (____)____ - _____ Home/Work/Cell Phone Number: (____)____ - _____ Home/Work/Cell
 I do NOT wish to have any of my information recorded on my personal voicemail.

I HEREBY AUTHORIZE ONE OR ALL OF THE PARTIES BELOW TO REQUEST AND RECEIVE ANY PROTECTED HEALTH INFORMATION VERBALLY OR IN A VOICEMAIL MESSAGE AS DESIGNATED BELOW. I UNDERSTAND THAT THE IDENTITIES OF EACH DESIGNATED PARTY MUST BE VERIFIED BEFORE THE RELEASE OF ANY INFORMATION.

I do NOT wish to have any of my information released to someone other than myself.

Name: _____ Relationship: _____ Phone Number: (____)____ - _____
May speak with them in regards to: Appointments Treatments Payments/Billing Diagnostic Test Results

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May speak with them in regards to: Appointments Treatments Payments/Billing Diagnostic Test Results

I UNDERSTAND THAT THE INFORMATION ABOVE WILL BE USED UNTIL I NOTIFY Wild Health Asheville IN WRITING IF A CONTACT(S) SHOULD NO LONGER BE USED.

Signature: _____ Date: ____/____/____

Name if parent/guardian signature (please print): _____

Patient Name: _____ **DOB:** _____

Allergies to Medications: No known drug allergies
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Other Allergies: _____

Family Medical History:

Mother's Health Conditions: _____

Living? Y / N If deceased, what was her cause of death, at what age? _____

Father's Health Conditions: _____

Living? Y / N If deceased, what was his cause of death, at what age? _____

Sibling's Health Conditions: _____

Tobacco Use:

- Never smoked
- Current cigarette smoker Start year: _____ Packs per day: _____
- Current e-cigarette/vapor Start year: _____ Times per day: _____
- Smokeless tobacco Start year: _____ Times per day: _____
- Former tobacco user Start/Quit year: _____ Packs per day: _____

Caffeine Use:

- None Coffee Tea Soda Energy drink Servings per day: _____

Drug Use:

- Never Current drug use Past drug use, quit date: ____/____/____
- Drug used: _____ Rarely 1-2/year 1-2/day 3-4/week 1-2/month
- Drug used: _____ Rarely 1-2/year 1-2/day 3-4/week 1-2/month

Alcohol Use:

- Never Rarely 1-2/year 1-2 drinks/day 2-3 drinks/day 4+ drinks per day

Living Situation: Who lives at home with you? _____

Exercise: _____ minutes/day _____ days/week Activity type: _____

Are you currently sexually active? No Previously Yes, number of partners in past 3 months: _____

Do you have a history of STIs? No Chlamydia Herpes Gonorrhea Syphilis HIV AIDs

Have you traveled outside the U.S in the past year? No Yes, date of travel: ____/____/____ Country: _____

Medications: Please list any prescription medications you take on a daily basis.

- None
- Name: _____ Strength: _____ Frequency: _____
- Name: _____ Strength: _____ Frequency: _____
- Name: _____ Strength: _____ Frequency: _____
- Name: _____ Strength: _____ Frequency: _____
- Name: _____ Strength: _____ Frequency: _____

Vitamins/Supplements: Please list any over the counter vitamins or supplements you are currently taking.

- None
- Name: _____ Strength: _____ Frequency: _____ Reason: _____
- Name: _____ Strength: _____ Frequency: _____ Reason: _____
- Name: _____ Strength: _____ Frequency: _____ Reason: _____

Preferred local pharmacy: _____ **Mail Order (if applicable):** _____

Previous surgeries or hospitalizations: None

- Procedure/Reason: _____ Date: ____/____/____ Hospital/Surgeon: _____
- Procedure/Reason: _____ Date: ____/____/____ Hospital/Surgeon: _____
- Procedure/Reason: _____ Date: ____/____/____ Hospital/Surgeon: _____

Specialists: Do you see any other medical providers? (Dermatologist, ophthalmologist, cardiologist, gynecologist, etc.)

- Office/Doctor: _____ Why? _____ Date of last visit: ____/____/____
- Office/Doctor: _____ Why? _____ Date of last visit: ____/____/____

Office/Doctor: _____ Why? _____ Date of last visit: ___/___/___

Preventative Screenings:

Last annual physical, Date: ___/___/___ Office: _____
Colonoscopy, Date: ___/___/___ Office: _____ Results: Normal Abnormal
DEXA (bone density), Date: ___/___/___ Office: _____ Results: Normal
 Abnormal
PAP Smear, Date: ___/___/___ Office: _____ Results: Normal Abnormal
Mammogram, Date: ___/___/___ Office: _____ Results: Normal Abnormal

Immunizations:

Hepatitis B: No Yes, date: ___/___/___ Pneumonia: No Yes, date: ___/___/___
HPV: No Yes, date: ___/___/___ Zostavax (Shingles): No Yes, date: ___/___/___
Influenza: No Yes, date: ___/___/___ Tetanus: No Yes, date: ___/___/___

Do you wear your seat belt? Yes No Are there smoke detectors in your home? Yes No
Do you have any advanced directives? (living will, durable power of attorney for medical decisions) Yes No

Past Medical History: PLEASE CHECK ANY CONDITIONS YOU HAVE BEEN DIAGNOSED WITH IN THE PAST.

| | | |
|--------------------------------------------|--------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> DVT or PE (blood clots) | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Digestive disorder | <input type="checkbox"/> Thyroid disease |

Review of Systems: Please check any of the following symptoms you are experiencing today or have in the past month that you would like to discuss with the provider.

General: Fever Fatigue Weight Gain Weight Loss
Skin: Change in wart or mole Rash New lesion of concern
EENT: Visual Loss Hearing Loss Ringing in Ears Nose Bleed Sore Throat
Respiratory: Cough Difficulty Breathing Shortness of Breath Snoring Wheezing
Cardiovascular: Chest Pain Heart Murmur Irregular Heartbeat Leg Pain / Swelling
Gastrointestinal: Abdominal Pain Blood in Stool Constipation Diarrhea Heartburn Nausea
Females: Vaginal Bleeding Irregular Periods Currently Pregnant Last Menstrual Period: ___/___/___
Males: Change in stream Difficulty with erection Hesitancy Urethral Discharge Testicular Mass/Pain
Musculoskeletal: Back Pain Joint Pain Joint Stiffness Joint Swelling Muscle Weakness Muscle Pain
Neurological: Decreased Memory Dizziness Headache Numbness Seizures Tremor
 Weakness
Psychiatric: Anxiety Depression Hallucinations Insomnia Mood Changes Nervousness Panic Attack
Endocrine: Cold Intolerance Excessive Thirst Excessive Urination Hot Flashes Libido Changes
Hematology: Blood Clots Bruise Easily

Consent to Treatment: By signing below I verify that the information above is true and complete to the best of my knowledge. I hereby consent to evaluation, testing, and treatment as directed by the medical providers at Authentic Health, PLLC.

Signature: _____ Date: ___/___/___

Name if parent/guardian signature (please print): _____