Abundant Life
HEALTH CARE

The complete balance of health, energy & wellness you can trust.

Date_____

NEW PATIENT INTAKE:

Name: _____ DOB: _____ ☐ Female ☐ Male

Mailing Address:_____

City: _____ State: _____ Zip: _____

Last 4 #s S.S. _____ Cell #_____ Home # _____Work # _____

Occupation: _____ ☐ F/T ☐ P/T ☐ Retired ☐ Unemployed

E-mail address: _____

Would you like to receive our e-mail newsletter? ☐ YES ☐ NO THANK YOU

Emergency Contact: _____Phone Number:_____ Relationship: _____

Whom may we thank for your referral? _____

WE ARE NOT A CONTRACTED MEDICARE/MEDICAID PROVIDER. By Law our Providers are able to provide medical services to Medicare beneficiaries only if they enter into a contractual agreement acknowledging that they fully understand: **1)** Medicare **WILL NOT** reimburse you for any services rendered at Abundant Life Health Care **2)** Medicare cannot be billed for any of our services by our Providers or you. **3)** You are financially responsible for all charges for services rendered to you by our Provider. **4)** We are not binded to Medicare's fee schedule. **5)** You are free, at any time, to seek services of a Medicare Provider.

☐ I, _____, a Medicare beneficiary, have read and understand all the above terms and conditions and agree to accept them in full, as a requirement for medical care by Abundant Life Health Care.
☐ I am not a Medicare beneficiary; I understand that Abundant Life Health Care is not a Medicare provider.

Although we are not contracted with any insurance companies - **please bring your health insurance card(s)/Medicare card with you.** We keep a photocopy in your file and use it when preauthorization is required for a prescription or procedure.

At the end of your visit you will receive an itemized statement with all the appropriate medical codes. This will allow you to submit a claim to your insurance company should you choose to do so.

_____

SIGNATURE OF RESPONSIBLE PARTY: **DATE:**

_____

Print Name of Patient

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Name:_____ **DOB:**_____

Personal Health History: Do you have, or ever had any of the following? ***Check all that apply.***

☐ Allergies	☐ Bowel Problems	Heart Problems	☐ Migraine Headaches
☐ Anemia	☐ Breathing Problems	☐ High Blood Pressure	☐ Nerve Problems
☐ Alcohol/drug	☐ Cancer _____	☐ High Cholesterol	☐ Seizures
☐ Arthritis	☐ Depression	☐ Insulin Resistance	☐ Skin Problems
☐ Asthma	☐ Diabetes _____	☐ Kidney Problems	☐ Stroke
☐ Back Pain	☐ Eye Problems	☐ Liver Problems	☐ Thyroid Problems
☐ Blood Transfusion	☐ Serious Injury _____		☐ Ulcers

Current Medications: Please include Prescription and OTC (over the counter) medications.

Name of Medication:	Dosage:	Taken how many times/day:

Medication Allergies: ☐ None ☐ Yes/List

_____

List Any Hospitalizations or Surgeries:

Year:	Procedure/Reason:	Doctor:	Hospital:

Family History:

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Current age:						
Age at Death:						
Cause of Death:						
Heart Disease:						
High Blood Pressure:						
Stroke:						
Cancer/Type						
Glaucoma						
Diabetes/Epilepsy:						
Bleeding Disorder:						
Kidney Disease:						
Thyroid Disease:						
Mental Illness:						
Other:						

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Name_____ **Date:**_____

Social History:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Tobacco Use: ☐ None ☐ Chewing tobacco ☐ Cigar/ Pipe

☐ Cigarettes _____ packs/day for _____ years - quit date:_____

Alcohol Use: ☐ None ☐ Type of drink_____ #drinks/week_____

Recreational Drug Use: ☐ Type of drug _____ #times/week_____

Exercise: ☐ Daily ☐ Weekly _____#times/week ☐ Aerobic ☐ Weight Training

Immunizations/ Screening Exams: **(date of most recent)**

☐ hepatitis B _____ ☐ Pneumovax _____ ☐ tetanus _____ ☐ flu shot _____

☐ stool-blood _____ ☐ chest x-ray _____ ☐ TB test_____ ☐ colonoscopy_____

Women ONLY:

Last Pap Smear _____Any Abnormal Pap Smears? ☐ Yes ☐ No

Last Mammogram _____Any Abnormal Mammograms? ☐ Yes ☐ No

Have you had bone density testing? ☐ Yes ☐ No Year:_____

Do you perform Breast Self-Exams? ☐ Yes ☐ No If Yes, how often? _____

Age you started your periods: _____ Are they regular? ☐ Yes ☐ No

Do you still have periods? ☐ Yes ☐ No Number Of Days Between Periods (average)_____

Have you ever taken hormone replacement therapy? ☐ Yes ☐No

How many times have you been pregnant? _____ How many children do you have?_____

Number of vaginal deliveries:_____Number of C-Sections? _____Miscarriages/Abortion?_____

Current Birth Control Method: _____ ☐ Not Applicable

Men ONLY:

Last Prostate Exam: _____ Any Abnormal Prostate Exams? ☐ Yes ☐ No

Last Testicular Exam: _____ Do you perform testicular self-exams? ☐ Yes ☐ No

Additional Information:

_____

_____

_____

_____

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