Nutura Clinic
1675 SW Marlow Ave, Suite 301
P97225ortland, OR 97225
Phone: 503-298-4104
Fax: 503-379-0967
www.nuturaclinic.com

New Patient Intake Form

I. PATIENT INFORMATION:

Last Name:_______________________________First_______________________MI_____Date of Birth____/_____/______

Address:____Apt#:______ Gender: M / F Age: __________

City:_____________________________ State:________Zip code: ______________ Home # ______________________

Email: ____ Mobile # ______________________

Current Weight ______________ Height ________________ ** **Ok to leave voicemail** Yes / No

Employed? (circle one): Y / N / Full-time / Part-time / Retired Occupation: ____________________________

Company Name:____Work # __________________________

Marital Status (circle one) Single / Married / Partnered / Divorced / Separated / Widowed

Partner's Name:____ Phone #______________________

Number of Children:__________________________ Number of members in your household: ____________________

Name of your Primary Care Physician or Referring Physician: ____

II. IN CASE OF EMERGENCY:

Person to Contact____ Relationship to Patient _________________

Home # _________________________ Cell # _________________________ Work # _________________________

***III.* BILLING:** *Verification of benefit does not guarantee payment from your insurance. You will be responsible for payment in the event insurance deems service(s) not payable under your plan.*

How do you intend to pay? (Circle) Medical Ins / Myself / Other: ____

Primary Ins________________________ID #:____________________Grp #:____________Ph # ____________________

Subscriber's Name:____ Date of Birth______/____/_______

Secondary Ins______________________ID #:____________________Grp #:____________Ph # ___________________

Insured's Name:____ Date of Birth______/____/______

How did you hear about us?____

____

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HEALTH QUESTIONNAIRE

I. CURRENT HEALTH PROBLEMS:

Please describe your current health concerns and indicate how long you've had these issues.

____

____

____

FOR WOMEN ONLY**:** Are you pregnant or may become pregnant? Yes / No Are you currently nursing? Yes / No

List all medications or supplements you are currently taking (Name and dosage)

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Tobacco use? Current / Past / Never How much? ______________

Alcohol? Current / Past / Never How much? ______________

Recreational drugs? Current / Past / Never How much? ______________

List all known allergies including the specific reactions:

Food Allergy ______________________________ Medication Allergy ______________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Please list any previously diagnosed health conditions.

____

List any past surgeries: ____

____

II. FAMILY HISTORY:

Mother: Deceased__________Living __________

Has she had any of the following health problems:

Cancer Y N type:____________________

Heart Conditions/High BP Y N type:____________

Diabetes Y N

Osteoporosis Y N

Dementia Y N

Father: Deceased________Living __________

Has he had any of the following health problems:

Cancer Y N type:____________________

Heart Conditions/High BP Y N type:____________

Diabetes Y N

Osteoporosis Y N

Dementia Y N

Other relatives (sibling, grandparents, aunts, uncles, etc.) with significant health problems:

____

____

____

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FINANCIAL TERMS AND CONDITIONS

NOTICE OF PRIVACY PRACTICE: Our office does not disclose any protected any personal or medical information without a signed a release and authorization from the patient or the patient's guardian. A patient may request restrictions on certain uses and disclosures of the protected information. Patients have the right to inspect and copy health information, including medical records. Patients have the right to an accounting of disclosure of protected health information. **I am aware that communication through the internet (email, etc.) is not protected by HIPAA and is not secure.**

RELEASE OF INFORMATION: I agree that to the extent necessary to determine liability of payment, and to obtain reimbursement, this office may disclose portions of my records, including my medical records to any person or corporation which is or maybe liable, for all or any portion of the office's charges. This may include, but is not limited to, insurance companies or worker's compensation carriers. I certify that providers at Nutura Clinic have my consent to use my records for the purpose of diagnosis, treatment, continuity of care, and billing.

ASSIGNMENT OF INSURANCE BENEFITS: In the event I am entitled to insurance benefits arising out of any policy insuring myself or any party liable to me, I assign said benefits directly to this medical office for application to my bill. I agree Nutura Clinic may issue a receipt for such payment, that such payment shall discharge the insurance company of any and all obligations under the policy to the extent of the payment, and that I shall be responsible for all charges not covered by this agreement, including making co-payments prior to medical services.

FINANCIAL AGREEMENT: I hereby agree that in consideration for services rendered by this office, I shall make prompt payments to my account as bills are presented. I agree to pay late fees as detailed below should the account become delinquent.

______**$80 will be charged for every appointment canceled with less than 24-hour notice or no-show. $35.00 fee for every non-sufficient funds check (NSF).**

FINANCIAL AGREEMENT FOR THE RESPONSIBLE PARTY OTHER THAN THE PATIENT: I am financially responsible for all charges incurred by the patient stated above. I agree to make payment in full in the event his/her insurance deems service(s) not payable. With my signature below I agree to the above Financial Terms and Conditions. ***I am financially responsible for all charges incurred at the time of my visit. I agree to make payment in full in the event my insurance deems service(s) not payable.***

I agree to the above conditions of treatment and understand this document will be kept as part of my permanent chart. My signature below also indicates that all information provided in this document is truthful to the best of my knowledge.

Patient Signature:____ **Date:** ____________________

Guardian Signature: ____ **Date:**____________________