Center of Health

2612 E. Barnett Rd. Medford, Oregon 97504
541-773-3191 Fax 541-779-5647

Patient Intake and Consent Form

Last Name ______________________ Today's Date ____________
First Name ______________ MI ____ Home Phone ____________
Address ______________________ Work Phone ____________
______________________ Cell Phone ____________
City ________ State ________ Zip ________ Date of Birth ____________
Age ______ Sex M F

Responsible Party ______________________ Soc. Sec# ____________
Address ______________________ Marital Status S M D W
______________________ Height ________ Weight ________
City ________ State ________ Zip ________ E-Mail ____________
Home Phone ____________ SS# ________ Accident Related Yes No
Relationship to Patient: Spouse Parent Child Other If Accident: Work Auto Other
Nature of Accident ____________

Employer ______________________
Address ______________________ Occupation ____________
City ________ State ________ Zip ________ May we call at your work? Y N

Referred by: Phone Book ______ Patient (Name) ______________________
Other ______________________

Primary Insurance ______________________ ID # ____________
Address ______________________ Group # ____________
City ________ State ________ Zip ________ Phone # ____________
Insured Name ______________________ Date of Birth ____________
Relationship to Patient: Spouse Child Other SS# of Insured ____________

Secondary Insurance ______________________ ID # ____________
Address ______________________ Group # ____________
City ________ State ________ Zip ________ Phone # ____________
Insured Name ______________________ Date of Birth ____________
Relationship to Patient: Self Spouse Child Other SS# of Insured ____________

Emergency Contact ______________________ Daytime Phone # ____________

CONSENT TO TREATMENT: I consent to treatment and related services at CENTER OF HEALTH.

______ (Please Initial)

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to CENTER OF HEALTH and also authorize release of any medical records necessary to process medical claims. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I understand that insurance policies are a contract between myself and the insurance company and that I am personally responsible for all services/products that I receive.

______ (Please Initial)

CANCEL/NO SHOW POLICY: I understand that CENTER OF HEALTH requires a 24 hour notice for all cancelled appointments. Failure to cancel appointments prior to 24 hours will result in a $50.00 charge to my account. Insurance will not cover this fee.

______ (Please Initial)

ACCOUNT COLLECTION: I understand that CENTER OF HEALTH will make every to effort for payment arrangements for balances owed. Failure to make payments as agreed will result in the account being sent to a collection agency for collection proceedings. This will effect my credit score. CENTER OF HEALTH reserves the right to charge 12% APR on all unpaid balances.

______ (Please Initial)

NOTICE OF PRIVACY: I acknowledge receipt to Notice of Privacy Practices.

______ (Please Initial)

I certify that all information provided herein is true and correct. Today's Date ____________

Patient/Guardian Signature ______________________________

PRESENT COMPLAINTS

Describe symptom(s) of condition(s) for which you are seeking care: ________________

What brought it about? (injury, accident or other?) ________________

How long has this been a problem? ________________

When or what makes it feel better? ________________

When or what makes it feel worse? ________________

Describe previous care you have received for this condition:

Date	Doctor	Findings	Treatment/Drugs	Response

Last Physical Examination: Year ________ Where ________________

Have you had any of the following tests? If so where/when?

Test			
Routine blood work	☐ Yes	☐ No	When/Where ________
Cholesterol screening (lipid panel)	☐ Yes	☐ No	When/Where ________
Thyroid Testing	☐ Yes	☐ No	When/Where ________
Hormone profile	☐ Yes	☐ No	When/Where ________
Bone Density Scan	☐ Yes	☐ No	When/Where ________
MRI/X-rays	☐ Yes	☐ No	When/Where ________
Pap/Pelvic exam	☐ Yes	☐ No	When/Where ________
Allergy panel	☐ Yes	☐ No	When/Where ________

Have you ever had an allergic reaction to medication (prescription or over-the-counter)?

Medication	Reaction

Are you currently taking any vitamins, supplements, prescriptions or over-the-counter medications?

Medications	Strength	Dosing	Brand (Vitamins)