



Patient Intake Form 2022

Print clearly. Complete all information.

v.3 04.22.22

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)	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	PREFERRED LANGUAGE	<input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> ARABIC <input type="checkbox"/> 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	EQUAL TO OR OVER				
1	<input type="checkbox"/> \$13,590	<input type="checkbox"/> \$16,988	<input type="checkbox"/> \$20,385	<input type="checkbox"/> \$23,783	<input type="checkbox"/> \$27,180	<input type="checkbox"/> \$27,181
2	<input type="checkbox"/> \$18,310	<input type="checkbox"/> \$22,888	<input type="checkbox"/> \$27,465	<input type="checkbox"/> \$32,043	<input type="checkbox"/> \$36,620	<input type="checkbox"/> \$36,621
3	<input type="checkbox"/> \$23,030	<input type="checkbox"/> \$28,788	<input type="checkbox"/> \$34,545	<input type="checkbox"/> \$40,303	<input type="checkbox"/> \$46,060	<input type="checkbox"/> \$46,061
4	<input type="checkbox"/> \$27,750	<input type="checkbox"/> \$34,688	<input type="checkbox"/> \$41,625	<input type="checkbox"/> \$48,563	<input type="checkbox"/> \$55,500	<input type="checkbox"/> \$55,501
5	<input type="checkbox"/> \$32,470	<input type="checkbox"/> \$40,588	<input type="checkbox"/> \$48,705	<input type="checkbox"/> \$56,823	<input type="checkbox"/> \$64,940	<input type="checkbox"/> \$64,941
6	<input type="checkbox"/> \$37,190	<input type="checkbox"/> \$46,488	<input type="checkbox"/> \$55,785	<input type="checkbox"/> \$65,083	<input type="checkbox"/> \$74,380	<input type="checkbox"/> \$74,381
7	<input type="checkbox"/> \$41,910	<input type="checkbox"/> \$52,388	<input type="checkbox"/> \$62,865	<input type="checkbox"/> \$73,343	<input type="checkbox"/> \$83,820	<input type="checkbox"/> \$83,821
8	<input type="checkbox"/> \$46,630	<input type="checkbox"/> \$58,288	<input type="checkbox"/> \$69,945	<input type="checkbox"/> \$81,603	<input type="checkbox"/> \$93,260	<input type="checkbox"/> \$93,261

Emergency Contact Information

LAST NAME		FIRST NAME	
RELATIONSHIP	STREET ADDRESS		
CITY, STATE	ZIP CODE	PHONE (CELL)	
PHONE (HOME)	PREFERRED LANGUAGE	<input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> ARABIC <input type="checkbox"/> OTHER _____	



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?		<input type="checkbox"/> PARENT/GUARDIAN	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> SELF	<input type="checkbox"/> 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	<input type="checkbox"/> JR.	<input type="checkbox"/> SR.	<input type="checkbox"/> 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	<input type="checkbox"/> JR.	<input type="checkbox"/> SR.	<input type="checkbox"/> 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	<input type="checkbox"/> DOCUMENTS REVIEWED	<input type="checkbox"/> PAY STUB	<input type="checkbox"/> TAX STATEMENT	<input type="checkbox"/> W2	<input type="checkbox"/> LETTER OF SUPPORT	<input type="checkbox"/> _____



PATIENT NAME _____

DATE OF BIRTH _____

Patient Background

Race	Ethnicity	Gender Identity	Sexual Orientation
<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> TWO OR MORE <input type="checkbox"/> WHITE (CAUCASIAN) <input type="checkbox"/> UNREPORTED/ REFUSED TO REPORT	<input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO Place of Birth <input type="checkbox"/> UNITED STATES <input type="checkbox"/> OTHER, PLEASE SPECIFY _____ _____ _____	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> NEITHER EXCLUSIVELY MALE NOR FEMALE <input type="checkbox"/> TRANSGENDER FEMALE-TO-MALE <input type="checkbox"/> TRANSGENDER MALE-TO-FEMALE <input type="checkbox"/> DECLINE TO ANSWER <input type="checkbox"/> OTHER _____	<input type="checkbox"/> BISEXUAL <input type="checkbox"/> LESBIAN, GAY <input type="checkbox"/> SOMETHING ELSE <input type="checkbox"/> STRAIGHT (NOT LESBIAN OR GAY) <input type="checkbox"/> DON'T KNOW <input type="checkbox"/> DECLINE TO ANSWER

Housing Status

ARE YOU HOMELESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU A VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES: <input type="checkbox"/> SHELTER <input type="checkbox"/> STREET <input type="checkbox"/> DOUBLING UP <input type="checkbox"/> TRANSITIONAL HOUSING	

Programs

DO YOU CURRENTLY GET FOOD STAMPS? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU CURRENTLY GET WIC? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU NEED HELP PAYING FOR YOUR MEDICINE? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Neighborhood Health 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?	<input type="checkbox"/> ALWAYS	<input type="checkbox"/> OFTEN	<input type="checkbox"/> SOMETIMES	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> NEVER
B. HOW OFTEN DO YOU HAVE A PROBLEM UNDERSTANDING WHAT IS TOLD TO YOU ABOUT YOUR MEDICAL CONDITION?	<input type="checkbox"/> ALWAYS	<input type="checkbox"/> OFTEN	<input type="checkbox"/> SOMETIMES	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> NEVER

How Did You Hear About Us?

<input type="checkbox"/> FRIEND/FAMILY	<input type="checkbox"/> OUR STAFF	<input type="checkbox"/> GOOGLE	<input type="checkbox"/> FACEBOOK	<input type="checkbox"/> TWITTER
<input type="checkbox"/> OUR WEBSITE	<input type="checkbox"/> ADVERTISEMENT (POSTCARD, NEWSPAPER, ETC.)	<input type="checkbox"/> I SAW THE CLINIC	<input type="checkbox"/> COMMUNITY EVENT	<input type="checkbox"/> OTHER _____



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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOUR GUMS EVER BLEED? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER TAKEN ANTIBIOTIC PREMEDICATION TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> 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 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
- INCONTINENCE
- INFECTIOUS MONONUCLEOSIS
- IRRITABLE BOWEL SYNDROME

- KIDNEY STONES
- LUPUS
- MALARIA
- MIGRAINES/SEVERE HEADACHES
- MULTIPLE SCLEROSIS
- MUMPS
- MUSCULAR DYSTROPHY
- NASAL ALLERGIES/HAYFEVER
- OTHER BONE OR JOINT PROBLEMS

- OTHER LIVER, STOMACH OR BOWEL DISEASES

- OTHER MENTAL HEALTH PROBLEMS

- OTHER NEUROLOGICAL PROBLEMS

- OTHER STD

- 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? YES NO

DO YOU SMOKE? YES NO

DO YOU TAKE RECREATIONAL DRUGS? YES NO

DO YOU VAPE? YES NO

PATIENT NAME _____

DATE OF BIRTH _____

	Summary	Full Details
Initial _____ Here	<p>I want to get the care that Neighborhood Health (NH) recommends for me.* It is okay for Neighborhood Health to treat me.*</p> <p>*or a minor child, if a minor child is the patient and I am the parent or legal guardian and I can authorize treatment.</p>	<p>I consent to the evaluation and treatment as may be deemed necessary or advisable in the judgment of a NH physician or other 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.</p>
Initial _____ Here	<p>I agree the insurance company, Medicare, TennCare, or other programs can pay my bill. I allow Neighborhood Health to keep these payments.</p>	<p>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. NH 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 NH.</p>
Initial _____ Here	<p>I agree to pay the fees I owe that are not covered by insurance, Medicare, TennCare, or other programs.</p>	<p>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.</p> <p>I understand NH 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.</p>
Initial _____ Here	<p>Neighborhood Health can contact me by phone, email, and text.</p>	<p>I give my permission for NH to contact me by phone, email, and text regarding appointments, lab results, billing, and announcements.</p> <p>I know I can opt out by telling NH I do not want to get messages in a particular form or way.</p>
Initial _____ Here	<p>NH offered me a notice about privacy. NH also offered me notice about my rights as a patient.</p>	<p>I have been offered (a) a copy of the NH's HIPAA Notice of Privacy Practices; and (b) Neighborhood's Health Patient Rights and Responsibilities. I know I can find these online at www.neighborhoodhealthtn.org. I also know NH will email or mail me a copy if I ask.</p>
Initial _____ Here	<p>I know NH will keep a copy of this.</p>	<p>I authorize NH to use a copy of these authorizations and assignments. NH will file any hard copy original. Your authorization remains valid unless and until you revoke it in writing.</p>
Initial _____ Here	<p>I know everyone is welcome at Neighborhood Health.</p>	<p>If I have been discriminated against based on race, color, or national origin, I know I can file a "Title VI" complaint with NH 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.</p>

I know 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: _____