

# Synergy Medical Patient Intake

## GENERAL INFORMATION

Name: \_\_\_\_\_ (Age): \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Marital Status: S M D W  
How did you hear about us? \_\_\_\_\_  
Names of Children: \_\_\_\_\_ Ages: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Do you have an Health Savings Account (HSA), Health Reimbursement Agreement (HRA) or Flexible Spending Account? (FSA)

Yes  No If yes, which one? \_\_\_\_\_

## ACCIDENT INFORMATION

Is this visit due to an accident?  Yes  No If yes, what type?  Auto  Work  Other Date of Accident \_\_\_\_\_  
Has the accident been reported?  Yes  No To Whom? \_\_\_\_\_ Claim Number \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

Name of *Your Health Insurance Co.* \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name if different than yours \_\_\_\_\_ Insured's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Name of *Your Health Insurance Co.* \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Name if different than yours \_\_\_\_\_ Insured's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Insured's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

**Signature of Patient/or Guardian of said Minor** \_\_\_\_\_ **Date** \_\_\_\_\_

## HEALTH HISTORY

Who is your primary care physician? (doctor and/or practice) \_\_\_\_\_

**Please check to indicate if you are currently experiencing any of the following conditions:**

- |  |  |   |  |                                     |
|--|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Eczema     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

**Please check to indicate if you have ever had any of the following:**

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> Aids/HIV           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        | _____                                       |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Stroke               | _____                                       |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Suicide Attempt      | _____                                       |

For Women: Are you currently pregnant?  Yes  No

Are you currently under drug and/or medical care?  Yes  No If yes, explain: \_\_\_\_\_

Please list any medications you are currently taking (Be sure to include dosage and frequency): \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had (type & date): \_\_\_\_\_

Please list any supplements you are currently taking (vitamins, minerals, herbs): \_\_\_\_\_

Are you currently on any blood thinners – (aspirin regimen included)?  Yes  No List Type: \_\_\_\_\_

**Contraindications: A few Procedures in the office should be avoided if patients have certain conditions.**

Please CHECK if you have any of the following:

- A pacemaker  Suffer from blood clots  Knee/ hip replacement  Local or systemic infection  Egg allergy
- Corticosteroid or Local Anesthetic Allergy  Additional allergies (please list): \_\_\_\_\_

**Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)**

- Heart Disease \_\_\_\_\_  Diabetes \_\_\_\_\_  Other: \_\_\_\_\_
- Cancer \_\_\_\_\_  Arthritis \_\_\_\_\_  Other: \_\_\_\_\_

Do you exercise?:  Yes  No How often?: 1X 2X 3X 4X 5X per week Other: \_\_\_\_\_

Which activities:  Running  Jogging  Weight Training  Cycling  Yoga  Pilates  Swimming  Other: \_\_\_\_\_

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

What is your daily/weekly intake of the following:

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Energy Drinks \_\_\_\_\_ cups/day Cigarettes \_\_\_\_\_ packs/day

**I hereby certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.**

Patient's / Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Reviewed Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Updated Signature \_\_\_\_\_ Date \_\_\_\_\_



**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT & CONSENT  
(CONSENT TO USE PHI)**

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**Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Bellevue Medical Center or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

**Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below, I give my permission to use and disclose my health information  
as stated in the notice of privacy practices.***

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Full Name

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**Please check any services you would like more information about.**

- Physical Rehabilitation** - *involves stretching and strengthening the muscles of the body. Physical Rehabilitation is critical to correct postural issues.*
- Complimentary Chair Massage for you and your work team** - *Our massage therapists will come to your office and offer FREE massage for you and your co-workers or employees, at no cost to you!*
- Trigger Point Therapy** - *is an injection procedure used to eliminate painful areas of muscle that contain trigger points (knots) of muscle that form when muscles do not relax. Trigger points may irritate the nerves around them and cause referred pain, or pain that is felt in another part of the body.*
- Spinal Decompression** - *is the relief of pressure on a pinched nerve or bulged disc in the spine by producing negative pressure on the spinal discs with our state of the art CHATTANOOGA spinal decompression table.*
- Low Testosterone** - *Revitalize your libido, your energy and your life. Testosterone therapy for men can improve energy levels, low libido, and erection problems. Testosterone therapy can also improve blood sugar regulation in diabetic patients, decrease fat and drastically improve sleep.*
- Growth Hormone Releasing Peptide Treatment (Sermorelin)** - *Are you experiencing a decreased quality of life? Low muscle mass? Memory problems? Low energy and stamina? Difficulty losing fat? It may not be your testosterone. These are symptoms of Adult Growth Hormone Deficiency. Our hormone specialists offer testing and consultation for this condition. If detected and treated, your life can be dramatically improved.*
- Anti-Aging and Hormones** - *Natural solutions for balancing hormones. Ideal for patients that suffer from fatigue, stress, trouble sleeping, weight gain, etc. Find out if your symptoms are due to low testosterone (men) or imbalanced hormones (women).*
- Knee Regeneration Therapy** - *is a non-surgical solution for people that suffer from knee pain due to osteoarthritis of the knee. Knee Regeneration Therapy utilizes the most advanced procedures including laser treatment to improve tissue healing, visco-supplementation for joint lubrication, bracing along with strengthening of the musculature to prevent unwanted knee surgery and knee replacement.*
- Medical Weight Loss Program** - *Our Synergy Medical Weight Loss program combines food choice, portion control, behavior modification and physical activity with proven FDA approved medications to suppress your appetite, give you energy and burn fat. Synergy Medical's Weight Loss program is safe and successful and most patients report no side effects.*