# Medical Intake Form
# Dr. Greg Lamont-Mitchell ND

**Patient Identification and Contact Information**
Patient Name: _____ Date of Birth: _____ Age: ____ Sex: _____
Preferred Name: _____ Preferred Pronoun: _____
Home Street Address: _____
City: _____ _____ State: ____ Zip: _____ OK to send mail? ☐ Yes ☐ No

**Phone Numbers** OK to leave <u>confidential</u> message?
Home Phone: _____ ☐ Yes ☐ No
Cell/Mobile Phone: _____ ☐ Yes ☐ No
Work Phone: _____ ☐ Yes ☐ No

**Emergency Contact Information**
Name: _____ Relationship to Above Client: _____
Home Street Address: _____
City: _____ State: ____ Zip: _____ OK to leave message?
Home Phone: _____ ☐ Yes ☐ No
Cell/Mobile Phone:_____ ☐ Yes ☐ No

**Other Financially Responsible Party** (i.e. spouse)
☐ Same as above
Name: _____ Relationship to Above Client: _____
Home Street Address: _____
City: _____ State: ____ Zip: _____ OK to leave message?
Home Phone: _____ ☐ Yes ☐ No
Cell/Mobile Phone:_____ ☐ Yes ☐ No

**Work Information**
Employer: _____
Position: _____ How long have you been with this employer? _____

**Work-related Injury Information**
Date of Injury: _____ Nature of Injury:_____
Worker's Compensation (LNI) Caseworker: _____Case Worker Phone: _____
LNI Claim Number: _____

**Motor Vehicle Accident Information**
Date of Accident: _____ Case Manager: _____ Phone Number: _____
Auto Insurance Company to be billed: _____ Claim Number: _____

**Referral Information**
Who referred you to EBH? _____ Phone: _____
Address: _____
May I contact this person to thank them for the referral? ☐ Yes ☐ No

Are you currently applying for disability? ☐ Yes ☐ No
Are you planning to apply for disability in the next 6 months? ☐ Yes ☐ No
Are you involved in any pending law suits or legal action(s)? ☐ Yes ☐ No

**Please list your health concerns in order of importance:**

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

**What are your healthcare goals?** _____

_____

_____

**What do you know about my approach?** _____

_____

**What expectations do you have about working with Dr. Greg?** _____

_____

_____

**Are you currently receiving healthcare from another physician?** ☐ Yes ☐ No **If yes, from whom:**

_____

_____

**If no, when and for what reason did you last receive medical or health care?** _____

_____

**Please list all prescription medicines, over-the-counter medicines (OTC), and nutritional supplements or herbs you currently take: (**Please include name, dosage and purpose)

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____
11) _____
12) _____
13) _____
14) _____
15) _____

(Continue on a separate page)

**Please list all known allergies, intolerances and/or sensitivities (food, environmental, chemical):**

_____

_____

_____

**Diet**

Average breakfast: _____

_____

Average lunch: _____

_____

Average dinner: _____

_____

Snacks: _____

_____

How much <u>water</u> do you drink daily? _____

Do you follow any special diet? ☐ Yes ☐ No If yes, please describe:

_____

Tobacco ☐ Yes ☐ No What form?_____How much? _____
Alcohol ☐ Yes ☐ No How many drinks per week: _____
Caffeine ☐ Yes ☐ No How much daily:_____
Other ☐ Yes ☐ No What? How much per week? _____
What do you do for relaxation and/or fun? _____

Do you feel you have a support network (friends and family) you can turn to? ☐ Yes ☐ No

**Sleep**
Hours per night: _____ If you wake frequently, what is the reason? _____

Do you wake at the same time most nights? ☐ Yes ☐ No What Time? _____
Nightmares: ☐ Yes ☐ No Wake refreshed: ☐ Yes ☐ No Must nap during the day: ☐ Yes ☐ No
Sleep walk: ☐ Yes ☐ No Grind teeth: ☐ Yes ☐ No Snore: ☐ Yes ☐ No

**General**
Do you feel you have good energy? ☐ Yes ☐ No
If no, can you still do what you need to during the day? ☐ Yes ☐ No
Do you have fatigue? ☐ Yes ☐ No If yes, what are the best and worst times of day?

Describe your average mood: _____
Does your mood fluctuate often? ☐ Yes ☐ No If yes, please describe: _____

Do you experience frequent headaches? ☐ Yes ☐ No If yes, how often? _____
Do you experience Migraines? ☐ Yes ☐ No If yes, how often?_____
Have you ever had a head injury? ☐ Yes ☐ No If yes, please describe: _____

Concussion? ☐ Yes ☐ No If yes, please describe: _____

Loss of Consciousness? ☐ Yes ☐ No If yes for how long? _____

Frequent infections/colds/flu? ☐ Yes ☐ No How often? _____
Have you ever had a seizure? ☐ Yes ☐ No If yes, please describe: _____

**REGARDING THIS NEXT SECTION**:
Please circle (**Y**) if you **CURRENTLY** have the symptom, (**N**) if you've **NEVER** had the symptom, (**P**) if you had the symptom in the **PAST**.

| **Skin** | | | | | | |
|---|---|---|---|---|---|---|
| Eczema | Y | N | P | Color change | Y | N | P |
| Hives | Y | N | P | Lump | Y | N | P |
| Psoriasis | Y | N | P | Excessive Itching | Y | N | P |
| Dry skin | Y | N | P | Warts | Y | N | P |
| Excess Perspiration | Y | N | P | Easy Bruising | Y | N | P |
| Hair loss | Y | N | P | Oily skin | Y | N | P |
| Other: please explain | | | | | | | |
| **Musculoskeletal** | | | | | | |
| Weakness | Y | N | P | Arthritis | Y | N | P |
| Stiffness | Y | N | P | Muscle cramps | Y | N | P |
| Tremors | Y | N | P | Pain | Y | N | P |
| tingling | Y | N | P | numbness | Y | N | P |
| Other: please explain | | | | | | | |
| **Cardiovascular** | | | | | | |
| High blood pressure | Y | N | P | Rheumatic fever | Y | N | P |
| Low blood pressure | Y | N | P | Heart murmurs | Y | N | P |
| Arrhythmias | Y | N | P | Palpitations | Y | N | P |
| edema | Y | N | P | Chest pain | Y | N | P |
| Heart attack | Yes<br>No | | | Angina | Y | N | P |
| Other: please explain | | | | | | | |
| **Respiratory** | | | | | | |
| Cough | Y | N | P | Tuberculosis | Y | N | P |
| Shortness of breath | Y | N | P | Bronchitis | Y | N | P |
| Wheezing | Y | N | P | pneumonia | Y | N | P |
| Asthma | Y | N | P | Painful breathing | Y | N | P |
| Other: please explain | | | | | | | |
| **Gastrointestinal** | | | | | | |
| Heartburn | Y | N | P | Gall bladder disease | Y | N | P |
| Indigestion | Y | N | P | Diarrhea | Y | N | P |
| Gas | Y | N | P | Constipation | Y | N | P |
| Bloating | Y | N | P | Hemorrhoids | Y | N | P |
| Nausea | Y | N | P | Liver disease | Y | N | P |
| Vomiting | Y | N | P | Ulcer | Y | N | P |
| Abdominal pain | Y | N | P | Appetite | Good? ____<br>Poor? _____ | | |
| Other: please explain | | | | | | | |
| **Nervous system** | | | | | | |
| Paralysis | Y | N | P | Sciatica | Y | N | P |
| Seizures | Y | N | P | Fainting | Y | N | P |
| Dizziness/Vertigo | Y | N | P | Carpal tunnel syndrome | Y | N | P |
| Stroke | Y | N | P | Unexplained pain | Y | N | P |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Other: please explain | | | | | | | |
| **Mental/Emotional** | | | | | | | |
| Anxiety | Y | N | P | Panic attacks | Y | N | P |
| Depression | Y | N | P | High stress | Y | N | P |
| Suicidal Thoughts/Impulses | Y | N | P | Eating disorder | Y | N | P |
| Irritability | Y | N | P | Psychiatric disorders/diagnosis | Y | N | P<br>Type?_____ |
| ADD/ADHD | Y | N | P | Poor Concentration | Y | N | P |
| Brain Fog | Y | N | P | | | | |
| Other: please explain | | | | | | | |
| **Urinary tract** | | | | | | | |
| Incontinence | Y | N | P | Pain with urination | Y | N | P |
| Frequent urination | Y | N | P | Kidney stones | Y | N | P |
| Urgency | Y | N | P | Discharge | Y | N | P |
| Frequent infections | Y | N | P | Blood | Y | N | P |
| Other: please explain | | | | | | | |
| **Endocrine system** | | | | | | | |
| Hypothyroid | Y | N | P | Hyperthyroid | Y | N | P |
| Hypoglycemia | Y | N | P | Diabetes | Y | N | P |
| Excessive thirst | Y | N | P | | | | |
| Heat/cold intolerance | Y | N | P | | | | |
| Other: please explain | | | | | | | |
| | | | | | | | |
| **EENT** | | | | | | | |
| Hearing loss | Y | N | P | Vision changes | Y | N | P |
| Ringing in ears | Y | N | P | Eye pain | Y | N | P |
| Ear pain | Y | N | P | Dry eyes | Y | N | P |
| Sore throat | Y | N | P | Sores in mouth | Y | N | P |
| Hoarseness | Y | N | P | Tooth pain | Y | N | P |
| Trouble swallowing | Y | N | P | Frequent sinus infection/pain | Y | N | P |
| Nose bleeds | Y | N | P | | | | |
| Other: please explain | | | | | | | |

## Insurance Information Form

**Primary Insured Information** ☐ Check if Self
Name: _____ Phone: _____ Date of Birth: _____
Address: _____
Patient Name: _____ Date of Birth:_____ Relationship to you: _____
Insurance Company: _____ Customer Service Phone: _____
Address: _____
Primary Insured ID#: _____ Group ID#: _____

Evergreen Behavioral Health has my permission to bill my insurance company. I authorize Evergreen Behavioral Health to release any information necessary to process my claims. I further authorize that my insurance benefits be paid directly to Evergreen Behavioral Health.

Signature: _____ Date: _____

## Insurance Verification Form

As a new patient at Evergreen Behavioral Health, you are responsible for contacting your health insurance company to confirm the details of your coverage. Being informed allows you to plan your health care accordingly and avoid unexpected bills. Please complete this verification form, and present it to the Patient Services Specialist at your first appointment.

Patient Name:_____ DOB:_____Member ID #:_____Group #:_____

Name of Insurance Company:_____Customer Service Phone #:_____

Step 1: Call the customer service number on the back of your insurance card and speak with a live representative.
Step 2: Request benefit information for, "Naturopathic Physician coverage."
Step 3: Ask the Customer Service Representative the following questions:

- Representatives Name:_____**Deductible Amount**: $_____ **Deductible paid to date**: $_____
- **Co-pay** (due at the time of service): $_____
- **Co-Insurance**: %Insurance pays:_____ % Patient pays:_____% **Maximum # of visits per year**:_____
- Exclusions:_____
- Does my plan run on a calendar year? From (date)_____ to (date)_____
- Mailing address for claims:_____
- Is _____ (my EBH provider) **IN**-NETWORK? If not, do I have **OUT**-OF-NETWORK benefits?
    - **Out of Network Benefits**: Deductible $_____ Co-pay $_____ Co-Insurance $_____
    - Do I need **preauthorization**? ☐ Yes ☐ No Preauthorization #:_____

Step 4: Because **Biofeedback/Neurofeedback** or **Physiological Monitoring** may be recommended, ask the Customer Service Representative what procedure codes, listed below, are accepted:

| (CPT) Psychotherapy Codes | (CPT) Health and Behavior Codes |
|---|---|
| ___ **90901** Individual Biofeedback | ___ **96150** Initial Assessment of biopsychosocial factors (1 unit = 15 minutes) |
| ___ **90876** Individual Psychotherapy with biofeedback 45-50 minutes | ___ **96152** Individual Intervention Service - allows physiological recording (1 unit = 15 minutes) |

I have been informed that Evergreen Behavioral Health has not checked my benefits and I will be billed any amount my insurance company deems "patient responsibility." I understand that I am ultimately responsible for any fees incurred during my therapy at Evergreen Behavioral Health. In rare instances, I may receive an additional bill after my visit if the billing department discovers a billing discrepancy. I acknowledge any unpaid or overdue balances may be subject to collections.

Signature Date