Tammy Bennett, OMD
Patient Intake Form

PATIENT HISTORY

NAME:		ADDRESS:	
CITY:	ZIP:	STATE:	BIRTHDATE:

ILLNESS: Check "Y" if you have had any of these illness/problems or "F" if a family member has had any of these illness / problems.

Y	F	ILLNESS / DISEASE	Y		ILLNESS / DISEASE	Y	F	ILLNESS / DISEASE
		Alcoholism			Eye Problems			Rheumatic Fever
		Anemia			Glaucoma			Rubella, German Measles
		Anesthetic Reaction			Heart Disease			Stroke
		Asthma			High Blood Pressure			Suicide Attempt
		Cancer, Tumor			Kidney / Bladder Problems			Thyroid Disease
		Diabetes			Liver Disease (Hepatitis, Jaundice)			Ulcer (Stomach / Duodenum)
		Drug Abuse			Lung Disease, Tuberculosis			Uncontrolled Bleeding
		Depression			Mumps, Measles, Chicken Pox			Venereal Disease
		Eczema, Hives, Rashes			Nervous Breakdown, Mental Illness			Other
		Epilepsy			Phlebitis			

MEDICINE ALLERGIES:
List those medicines to which you are allergic and the type of reaction for each.

MEDICATIONS YOU ARE TAKING:
Please list all prescription and non-prescription medications.

HOSPITALIZATIONS:
Please list all illness / injuries / operations and the approximate year.

YEAR	ILLNESS / INJURY / OPERATION	HOSPITAL	CITY / STATE

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Have you ever had a blood transfusion? Yes or No?		
Any reaction to the transfusion? Yes or No?		
Do you smoke?	If yes, how many packs per day?	For how many years?
What about alcohol consumption? Yes or No?	If yes, how many drinks per day / week?	

PREGNANCY HISTORY

Please enter the number of:

TIMES PREGNANT		PREMATURE BIRTHS	
MISCARRIAGE		ABORTION	
LIVE BIRTHS		LIVING CHILDREN	
LIST ANY COMPLICATIONS:			

REVIEW OF SYSTEMS CHECKLIST:

Please check all that apply.

CONSTITUTIONAL					
	night sweats		recent illness		malaise
	anorexia		fatigue		weight gain / obesity
	chills		fever		
	sweating		insomnia		
EYES					
	blindness		eye foreign body		eyelid swelling
	eye discharge		eye pain		eyelid pain
	eye redness		eye tearing		vision change
	eye floaters		eye trauma		cataract
EARS / NOSE / THROAT / NECK					
	cancer		facial weakness		allergies
	ear wax		headache		nasal pain
	cosmetic deformity		hearing loss		polyps
	dental pain		hoarseness		neck pain
	dizziness		jaw pain		oral pain
	facial fracture		lacerations of head or neck		sinus congestion
	facial pain		nose bleeds		sleep apnea
	snoring		sore throat		
CARDIOVASCULAR					
	arrhytmia		fatigue		palpitations
	chest pain		high blood pressure		fainting
	swelling				
RESPIRATORY					
	asthma		cigarette smoke		snoring
	congestion		cough		vomiting
	chest tightness				
GASTROINTESTINAL					
	hemorrhoids		constipation		nausea
	hepatitis		diarrhea		vomiting
	abdominal pain		gas and bloating		

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	anorexia		jaundice		
GENITOURINARY / NEPHROLOGY					
	breast complaint		menstrual irregularity		testicular mass
	flank pain		night urination		testicular pain
	genital lesson		pap smear abnormality		urinary urgency
	blood in urine		pelvic pain		urinary frequency
	impotence		penile pain and discharge		urinary incontinence
	menopausal symptoms		pregnancy		vaginal discharge
MUSCULOSKETAL					
	stiffness		bone fracture		muscle weakness
	swelling		bone pain		muscle pain
	pain in joints		carpal tunnel syndrome		neck pain
	back pain		joint complaint		osteoporosis
	sciatica		shoulder pain		
DERMATOLOGIC					
	eczema		sores		skin cancer
	mole change		acne		skin lesion
	pigmentation change		cyst		
	rash		melanoma		
NEUROLOGIC					
	dizziness		back pain		speech difficulty
	headache		limp pain		fainting
	hearing loss		neck pain		weakness
	memory loss		facial pain		spasms
	mental status change		seizure		
PSYCHIATRIC					
	alcohol abuse		disturbance of consciousness		eating disorder
	drug abuse		disturbance of emotion		hallucinations
	anxiety		disturbance of memory		mania
	depression		disturbance of thinking		
	psychosis		suicidally		
ENDOCRINE					
	diabetes		hyperthyroidism		Chills
	elevated blood sugar		hypothyroidism		
	elevated cholesterol		obesity		
HEMATOLOGIC / LYMPHATIC					
	abnormal bleeding		abnormal bruising		anemia
ALLERGY / IMMUNOLOGY					
	nasal discharge		food allergies		

Phone #:		Cellphone:	Work:
Social Security #:		Occupation:	
E-mail:	Age:	Weight:	Height:
Referred by:			
Main Problem:			
Do you have any needs for skin tightening or skin rejuvenation?		Do you have sun spots?	
Are you unhappy with any areas of your body or weight?			

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TRADITIONAL CHINESE MEDICINE CHECKLIST

List of herbs:			
Time of day you feel the best?		Favorite Season:	
Favorite color to wear?			
Menstrual issues?			
Heavy?	Regular?	Menopause?	Age of first menses?

DIZZINESS, BALANCE AND HEARING SCREENING

Please check Yes or No for each item.

Name:	Date of birth:	Date:

BALANCE DYSFUNCTION SCREENING	**YES**	**NO**
1. Do you ever lose your balance when standing still?		
2. Do you feel the need to look for support or grab on to something when you are moving around?		
3. Do you have problems judging distance when walking?		
4. Do you use an assistive device (cane or walker) to move around?		
5. Have you fallen more than once the last year?		
6. Do you ever feel unsteady or lose your balance when walking?		
DIZZINESS / VERTIGO	**YES**	**NO**
1. Do you feel dizzy or light-headed?		
2. Have you ever suffered a stroke, head injury or neck trauma?		
3. Do objects appear to bounce or jump around?		
4. Do sudden changes in position make your dizziness worse?		
5. Do you experience vision problems such as blurred or double vision?		
6. Do you have an increased sensitivity to light and / or sound?		
HEARING	**YES**	**NO**
1. Do you feel pain or pressure in your ears when you feel dizzy?		
2. Do you experience a ringing or buzzing in your ears?		
3. Have you noticed a decrease in hearing?		
4. Do you ask people to repeat themselves?		

Speak with your physician about the questions you answered YES to because there are tests and treatments available that may improve your quality of life.

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INSURANCE INFORMATION

Date:			
Patient's Name:	Date of Birth:		
Address:	City:	State:	Zip Code:
Marital Status (Single / Married / Divorced / Widowed / Separated):			
Policy Member ID #:	Group #:		
Policy Holder Name:			
Policy Holder Address (if different from above):			
City:	State:	Zip Code:	
Date of birth of policy holder:	Social Security of policy holder:		
Insurance Company:			
Address of Insurance Company:			
City:	State:	Zip Code:	
Phone Number of Insurance Company:			
Relationship to injured:			

I, _____, authorize to submit a claim to my insurance company for my benefit. I understand that until my insurance company pays for my services I am responsible for the charges.

_____
Patient's Signature

_____
Date

_____
Legal Guardian

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AUTHORIZATION TO RELEASE / REQUEST MEDICAL RECORDS

Date of Request:	
Patient's Name:	Date of Birth:
Patient Phone:	

1. Information may be disclosed: TO ☐ FROM ☐

Tammy Bennett, OMD
917 Rinehart Road, Suite 2061 Lake Mary FL 32746
Phone: (407) 687-8451 Fax: **(407) 263-3044**

2. Information may be disclosed: TO ☐ FROM ☐

Name of Person / Practice:	
Address:	
Phone:	Fax:

3. Purpose of Disclosure

	Changing Physicians		Continuity of Medical Care
	Personal Use		Others:

4. Information to be disclosed:

	All Medical Records		Progress Notes
	History and Physical		Laboratory Results
	Radiology Results		Consultations
Other:			

I understand that the information in my health records may include information relating to sexually transmitted disease, required immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol abuse. This information is being provided to you from records whose confidentiality may be protected by State / Federal Law.

I understand that I may revoke this authorization in writing anytime and further understand that I must do so in writing and present my written revocation to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will automatically expire 90 days from the date initiated above.

Our notice of Privacy Practices provides information about our use of a patient's Protected Health Information (PHI). The notice contains a Patient's Rights section describing your rights under the law. Patients have the right to access, inspect and copy protected health care information used to make decisions about them.

Patient Signature: _____ Date: _____
Witness: _____

CONSENT TO REVIEW BLOOD WORK

I, _____, hereby voluntarily request that _____, review my current blood work for the purpose of nutritional evaluation. I understand that this is not a diagnosis of a specific illness or health condition, but a review of blood work for nutritional supplementation and lifestyle counseling based on Traditional Chinese Medicine.

I recognize that I am responsible for my health and well-being. It is my duty to be an informed partner in my assessment and treatment. To this end, I will secure the necessary self-knowledge to participate in my healing.

_____
Witness

_____
Patient's Signature

_____
Date

_____
Legal Guardian

INFORMED CONSENT AND WAIVER

I, _____, do hereby voluntarily request to receive clinical services from _____. I voluntarily consent that these services may include examination using Traditional Chinese Methods, differential diagnosis based in Chinese Medicine theory and Five Element Stimulation, Therapeutic Massage, Manual Therapy, Lifestyle Counseling, Hot and Cold Packs, biofeedback, Kinetic Therapies and Qi Gong therapeutic breathing techniques. I acknowledge that no guarantees have been made to me as to the effect of such examinations, treatments, therapy or care of my condition.

I further acknowledge that none of the above services are meant to be considered by me as the WESTERN diagnosis or treatment of disease. Such treatment and examinations are used as an aid to help my body produce varied physiologic effects to heal itself. Several examples of physiologic effects are stimulation of various gates within the Central Nervous System, production of serotonin, endorphins, norepinephrine and acetylcholine, B-endorphins and regulation of the autonomic nervous system to name a few.

I understand that prior to the beginning of any treatment procedure, I will receive an explanation of the nature and purpose of the treatment and any probable risks involved. I understand that I may refuse service at anytime. I recognize that I am responsible for my health and well-being. It is my duty to stay informed of my assessment and treatment.

I understand that payment by cash, check or credit card is due at the time of service.

I understand that all the clinical information will be kept confidential.

_____
Witness

_____
Patient's Signature

_____
Date

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PATIENT QUESTIONNAIRE

1. Please list the family members of other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health or operation):

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name:	Phone Number:
Name:	Phone Number:

3. Please print the address of where you would like your billing statement and/or correspondence from our office to be sent, if other than your home:

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked “CONFIDENTIAL”. Check which applies:

YES	NO

5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information if other than your home phone number:

6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine?

YES	NO

_____ _____

PATIENT’S SIGNATURE DATE

_____ _____

WITNESS DATE

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we chance our Notice, you may obtain a revised copy by contacting our offices.

You do have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we are, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such revocation shall not affect any disclosures we may have already made in reliance to your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke the Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

_____ _____

PATIENT'S SIGNATURE DATE

_____ _____

WITNESS DATE

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

Fees:

Our fees are determined by the complexity of each case and different services used.

Regarding Insurance:

We will verify coverage prior to treatment and we will file all claims as a courtesy to you. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you bring us all necessary insurance information. We are not a party to that contract. By signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document, you authorize the release of any information to any insurance company, adjuster or attorney that will assist in the payment of a claim. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed.

Usual and Customary Rates UCR:

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services may be non-covered services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. All payments are due at the time of service.

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit if you are a repeat offender of this rule. Your treatments will be more effective if you follow your physician's guidelines and stick to your treatment schedule. Please help us to improve you better by keeping your scheduled appointments. Please let us know if you have any questions or concerns.

I have read the financial policy and I agree to this financial policy.

_____ _____

PATIENT'S SIGNATURE DATE