Dr. Vanessa Newman, DO

Osteopathic Physician

Acorn Community Clinic

New Patient Intake Form

Welcome to our practice!

Today's Date: _____

Patient Name: _____ Date of Birth _____ Age: _____

Preferred Gender Pronouns: _____

Address(s): _____

_____

Home Phone(s): _____ Cell Phone(s): _____

Email Address(s): _____

Best place(s) to leave messages: □ Home □Cell

Number in household: _____

Children: _____ Occupation: _____

Employer: _____

Will you be submitting bills to an insurance carrier for reimbursement? □Yes □No

If yes: □Health or □Auto Insurance

Insurance Carrier: _____ Name on Policy: _____

Policy Holder DOB: _____-_____-_____

Please indicate if you receive coverage through:

□ Disability □ Work Comp □ Medicare

Emergency Contact: _____

Relationship: _____ Phone: _____

Referred by: _____

Reason for your visit today (please feel free to include a timeline on the back of this sheet if helpful):

_____

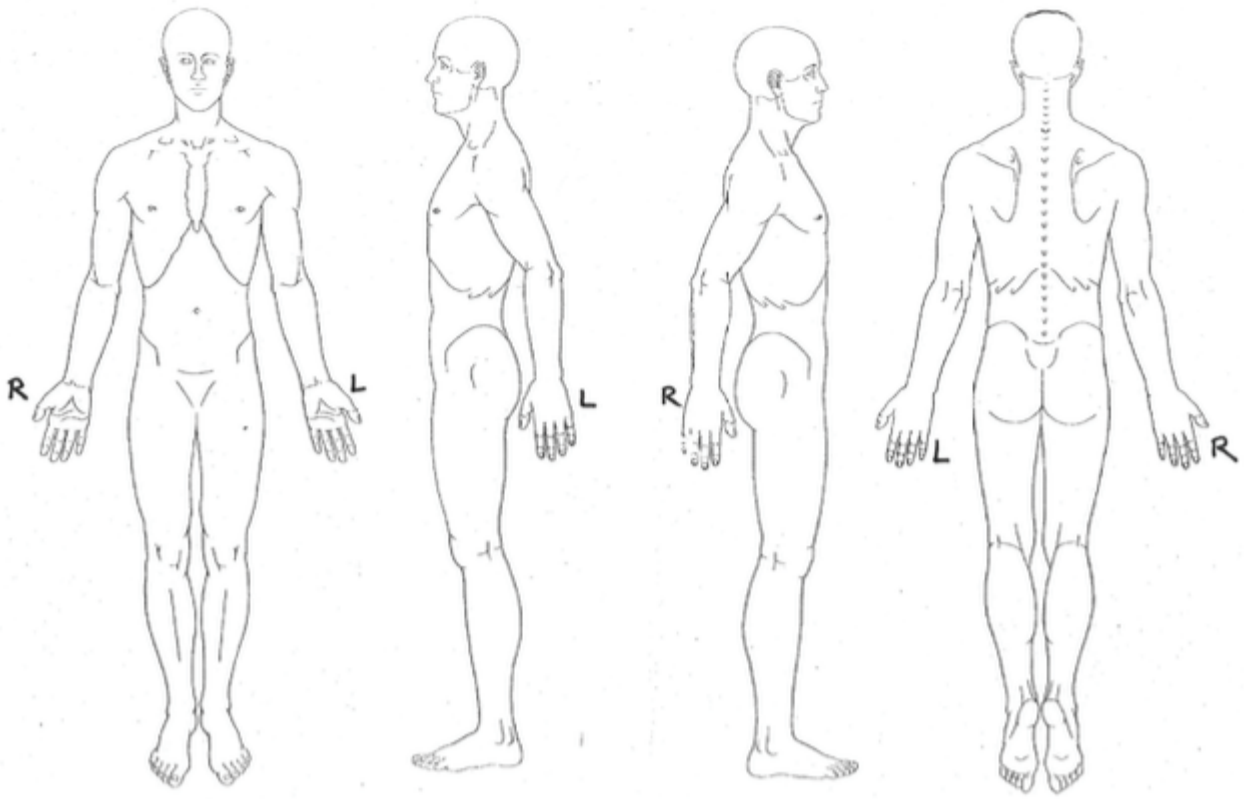
_____

_____

_____

Was there an inciting event, or anything different in your life, 6-12 months before this concern began?

_____



Please mark areas of pain/concern with an X.

Circle any areas of numbness/tingling.

Family History – Did any blood relative suffer any of the following? (Please indicate the following: M = mother; F = father; B = brother; S = sister; MGM = maternal grandmother; MGF = maternal grandfather; PGM = paternal grandmother; PGF = paternal grandfather)

_____ □ Epilepsy	_____ □ Asthma	_____ □ High cholesterol
_____ □ Migraine	_____ □ Anemia	_____ □ Alcoholism
_____ □ Mental Illness	_____ □ Bleeds easily	_____ □ Hepatitis
_____ □ Glaucoma	_____ □ Osteoporosis	_____ □ Cancer
_____ □ Diabetes	_____ □ Arthritis	_____ □ _____
_____ □ Thyroid	_____ □ Heart disease	_____ □ _____
_____ □ Hay fever	_____ □ Hypertension	_____ □ _____

Allergies (drugs, foods, environmental):

_____

Primary Care Physician and other healthcare practitioner(s) from whom you are *currently* receiving medical care:

Physician/ Practitioner	Condition being treated	Medications/Supplements

Please list all major medical problems/illnesses, surgeries, including major dental work and hospitalizations (indicate year/age, may continue on back as needed)

Year/age	

Describe all car accidents, injuries, head injury, falls, fractures or broken bones (include year/age occurred, may continue on back):

Year/age	

SOCIAL AND DIET HISTORY

Occupation(s) _____ Relationship status _____ # of Children _____
Exercise/Recreation/Hobbies_____
_____

Significant Sources of Stress
_____

Smoking (type & amount per day)_____ If ex-smoker, date quit_____

Other drugs (type & amount per day) _____

Alcohol (amount per week)_____ Caffeine (type & amount per day)_____

Sodas per week _____

Dietary Restrictions/Preferences_____

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Glasses of water per day _____ Date of Last Dental Exam_____

YOUR OWN BIRTH HISTORY (as much as possible)

Please Circle: Full-Term Premature Late Vaginal Delivery Cesarean Section Forceps/Vacuum

Number of Older Siblings_____ Number of Younger Siblings_____ Birth Weight _____
Complications/Interventions:_____

MEDICAL HISTORY

□ Decreased hearing
□ Ringing in ear
□ Ear infections
□ Dizzy or fainting spells
□ Failing vision or eye pain
□ Double or blurred vision
□ Nose bleeds – recurrent
□ Sinus trouble
□ Sore throats – frequent
□ Hoarseness – prolonged
□ Hayfever /Allergies
□ Pneumonia / Pleurisy
□ Bronchitis / Chronic cough
□ Asthma / Wheezing
□ Shortness of breath
□ On exertion □ Lying flat
□ Chest pain
□ High blood pressure
□ Heart murmur
□ Swollen ankles
□ Irregular pulse
□ Palpitations
□ Leg pain when walking
□ Varicose veins / Phlebitis
□ Cold numb feet
□ Loss of appetite - recent
□ Eating disorder
□ Difficulty swallowing
□ Heartburn
□ Peptic ulcer
□ Persistent Nausea / vomiting
□ Abdominal Pain - chronic
□ Gallbladder trouble
□ Jaundice / Hepatitis
□ Diarrhea □Constipation
□ Diverticulosis □ Crohn's / Colitis
□ Inflammatory Bowel Syndrome

□ Bloody or tarry stool
□ Hemorrhoids
□ Hernia
□ Urination / Overactive bladder
□ Overnight more than twice
□ More than 8 times / 24 hrs
□ Urgency to urinate
□ Decrease in force/flow □ Painful
□ Stress incontinence – urine leakage with exercise /movement
□ Blood in urine □ Kidney stones
□ Urine infections – frequent
□ Sexually transmitted diseases
□ Sexual concerns
□ Weight loss □ Gain – recent
□ Anemia □ Bruise easily
□ Blood transfusions
□ Cancer
□ Chronic fatigue
□ Diabetes
□ Thyroid disease
□ Seizures □ Stroke
□ Tremor / hands shaking
□ Numbness / tingling sensations
□ Headaches – frequent
□ Arthritis / Rheumatism
□ Back pain – recurrent
□ Bone fracture / joint injury
□ Osteoporosis/Osteopenia
□ Foot pain □ Gout
□ Unusual moles □ Rashes
□ Hives □ Psoriasis □ Eczema
□ Any type of sleeping difficulty
□ Snoring/Mouth breathing
□ Depression □ Nervousness
□ Agitation □ Memory loss
□ Moodiness □ Phobias

□ Suicidal thought □ Mental illness
□ Feelings of worthlessness
□ Rheumatic fever
□ Scarlet fever □ Mumps
□ Chickenpox □ Polio
□ Measles □ German measles
□ Tuberculosis □ Herpes
□ AIDS / HIV
□ Acupuncture / tattoos
□ Hair loss □ Progressive
□ Recent

MALES: □ Prostate problems

FEMALES *Please complete:*
Menstrual Flow:
Age of onset _____
□ Regular □ Irregular
□ Pain/Cramps
Days of flow _____
Length of cycle _____
Date of 1st day of last period_____
□ Pain / Bleeding during or after sex
Number of Pregnancies ____
Live Births:
Term_____ Preterm_____
Abortions ____
Miscarriages ____
Birth control method_____
□ Flushing / Menopause
Date of last PAP test
_____□ Normal □ Abnormal
Date of last mammogram
_____□ Normal □ Abnormal

Routine labs-- date of most recent: _____

Indicate any abnormal results: _____

Previous imaging/X-Rays: (Body Region and Reason for test)

X-ray _____

MRI _____

CT Scan _____

Sonogram _____

Other procedures: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my health. I also authorize the healthcare providers to perform the necessary health care services I may need, including Osteopathic Manipulation.

Signature_____Date_____

Dr. Vanessa Newman, DO
Acorn Community Clinic
phone (510) 526-5256 fax (510) 526-5547
liveoakmed@gmail.com

OFFICE POLICIES

Welcome! To help you get acquainted with our office, we have prepared a few words about our policies. If you have any questions or suggestions, please feel free to discuss these with us at any time. Please read and sign each form; this indicates to us that you have read and understand our guidelines.

Your Appointment: Appointments can be made either online or by phone. Every effort is made to examine newborn infants as soon as possible after birth. Special priority is also given to those with acute injuries or medical conditions and pregnant or post-partum women. Your appointment is time set aside for you to see your doctor. Note that we have a two-business day cancellation policy. *If you cancel an appointment less than two business days prior to its scheduled time, you will be billed the full visit fee.* Appointments may be cancelled online or by phone (please see our online instruction form). A message may be left on our voicemail at any time. The earlier you can inform us of a change in your plans, the sooner we can give your appointment to someone else in need.

Fragrances: Some of our patients are allergic to environmental pollutants, such as perfumes, scented body and hair care products. We would appreciate it if you refrained from wearing these to our office.

Cell phones: We make every effort to cultivate a tranquil, healing environment for our patients. Please refrain from using cell phones in the building and silence any ringers and alarms. Emergent calls can be taken outside the building. We appreciate your understanding.

Fees & Payment: *We require payment for services at the time they are provided.* We supply a standard itemized receipt, also known as a "superbill", which you may submit to your insurance company in case you qualify for reimbursement. ***Please note that Dr. Newman has opted out of Medicare****.*

In the case of minors, the parent or guardian who accompanies the minor is responsible for payment, even if the parents are separated or divorced and the person responsible for paying medical bills is not present at the time of the visit. If your check is returned from the bank, we will charge a $30.00 "return check" fee. For patients requesting photocopies of their medical records, a $25 copying fee applies.

Children: Children must be supervised by their caretaker. For their own safety, please do not allow children to roam about in other rooms or to touch electrical objects.

Thank you for taking the time to read this policy sheet. If you have any questions about this policy, please ask them now. We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery; however, we cannot guarantee any specific result.

I have read and understand the above policy and agree to it.

Patient/Guardian Signature: _____ Date: _____

Print Name of Patient/Guardian _____

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MEDICAL RELEASE FORM

Today's Date: _____

Patient Name: _____ Date of Birth _____-_____-_____
Please print

1. Permission to release information to Insurance Carriers:

I give permission to this office to release medical information to my health or automobile insurance company.

_____
Patient/Guardian Signature: _____Date

_____
Print Name of Patient/Guardian)

❑ Please contact me when you receive requests for information from my insurance carrier.

2. Permission to Share Information with Health providers:

I give permission to this office to share my medical information with my other health providers so that they may coordinate my care.

_____
Patient/Guardian Signature: _____Date

_____
Print Name of Patient/Guardian)

❑ Please contact me before sharing any information with my other health providers

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OFFICE PATIENT PRIVACY POLICY

In order to protect sensitive personal and medical information, we have instituted a number of measures aimed at maintaining your privacy. The National Institutes of Health have newly developed the *Health Insurance Portability and Accountability Act* (HIPAA), which requires that every medical provider makes a privacy policy available to their patients. This effort is set in place to maintain privacy of patient information in an era of high technology and data-laden medical systems. The following is the policy for patients of this office regarding patient privacy and confidentiality of information collected and stored in this office:

1. For payments and scheduling, our office manager will assist you.
2. An information sheet with demographic data, insurance information, consent for treatment and medical disclosure will be completed by every patient as part of her/his record. A copy of this sheet will be available to our office manager for billing purposes.
3. All superbills for office visits will be shared with the office manager in order to process insurance claims and record business transactions for tax purposes.
4. Any paper trash with patient information will be shredded prior to discarding it.
5. Employees and staff are required to sign a confidentiality agreement regarding any information they are exposed to in the office setting, which is not to be discussed or revealed to any person(s)/business(es) outside of the office setting without prior written consent by the patient/legal guardian.
6. Medical release forms are required to be signed by the individual or parent/guardian in order to release any medical information to themselves, medical offices, insurance companies, or to any other desired location. A copying charge may apply for extensive record copying.
7. All medical related conversations will occur in private.
8. All papers related to patient care will be stored in locked cabinets when not in use, where only authorized medical and administrative staff has access to them.
9. Any breach of confidentiality must be submitted in writing to Vanessa Newman, D.O. for proper action to be taken to amend the situation and/or policy.

I have read and understand the above Patient Privacy Policy.

_____

Patient/Guardian Signature: _____Date

_____

Print Name of Patient/Guardian

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HIPPA NOTICE OF PRIVACY PRACTICE - ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that a current copy of the medical practice's Notice of Privacy Practices is available online at www.hhs.gov/hipaa as well as in the reception area. I further acknowledge that a copy of any amended Notice of Privacy Practices will be available at each appointment.

_____

Patient/Guardian Signature: _____Date

_____

Print Name of Patient/Guardian

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MEDICARE BENEFICIARY AGREEMENT

Medicare beneficiary, clearly understand that by signing this contract, I will:

Agree not to submit a claim (for such items or services, even if such items or services are otherwise covered by Medicare).

Agree to be responsible, whether through insurance or otherwise, for payment of such items or services, and understand that no reimbursement will be provided for such items or services by Medicare.

Acknowledge that no limits apply to amounts that may be charged for such items or services.

Acknowledge that Medigap plans do not, and other supplemental plans may elect not to make payments for such items or services, because payment is not made with Medicare.

Acknowledge that, as a Medicare beneficiary, I have the right to such items and services provided by other physicians or practitioners, for whom payment would be made under Medicare.

Patient Signature: _____Date

_____
Print Name of Patient