Narberth Family Medicine
Andrew M. Lipton, D.O.
ALiptonDO@live.com

822 Montgomery Ave, Suite 315
Narberth, PA 19072
610-667-4601   610-667-6416fax

# History Intake Form

**Today's date: / /20**

First Name ___________________________ Birthdate: / /

Last Name __________________________________________ Social Security # - -

Address _____________________________________________________________________________________

Address 2nd line ______________________________________________________________________________

City _____________________________________________ State ______________ ZIP code _______________

Phone (hm) _________________________ (wk) _________________________ (cl) ________________________

Insurance Name/Pol #__________________________________________________________________________

**If your card says "Independence Blue Cross – Personal Choice" we are not in network with them.**

Email Address:_______________________________________________________________________________

How did you hear about us? We would like to thank them for the referral.

Family Member/Friend
Name _________________________________________________________________

Newspaper/Magazine
Which One? ___________________________________________________________

Internet
Which Site? ____________________________________________________________

Physician Referral
Name of Doctor ________________________________________________________

Other
_____________________________________________________________________

How would you classify your problem (circle): Minor Involved Serious

What is your main complaint?________________________________________________________________

________________________________________________________________________________

Other problems?_________________________________________________________________________

What is your goal or outcome?_______________________________________________________________

What would make today's visit successful?__________________________________________________

Previous & Other Physicians:_________________________________________________________

What is your occupation? ______________________________ Do you like your job? ________________

Do you have a spouse? _Y/N_Spouse's Name: ______________, Spouses Occupation_________________

How long are you together?_____Do you have any children? If so, names and ages:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**FAMILY HISTORY**

Please list all medical conditions/problems for the following family members

Mother ____________________________________________________________________________

Father ____________________________________________________________________________

Sister(s) __________________________________________________________________________

Brother(s) _________________________________________________________________________

Maternal Grandmother _______________________________________________________________

Paternal Grandmother _______________________________________________________________

Maternal Grandfather ________________________________________________________________

Paternal Grandfather ________________________________________________________________

## SURGICAL HISTORY

Have you ever had any surgeries? If so, list what type and date:___________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Have you ever been in the hospital overnight? Is so list reason and date:______________________________
________________________________________________________________________________________
________________________________________________________________________________________

## SOCIAL HISTORY

Do you smoke or did you ever smoke? ____ If so, how many cigarettes per day for how many years?______
When did you quit smoking?________________Do you want to quit smoking?Y/N

Do you drink alcohol? ______ Beer Wine Liquor (circle) How often? Daily Weekly Other

Do you drink coffee, tea or cola? ______ How many per day? ____________

What type of exercise, if any, do you do and how often? (circle all that apply)
Daily Weekly Strength Training Aerobics Yoga Pilates Other______________________

What Medications do you take? Prescribed by whom ____________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Allergies: Please include drugs, food, chemical ________________________________________________
________________________________________________________________________________________

How many hours do you sleep a night?_______________________________________________________

What Supplements do you take, if any? _________________________________
_________________________________ _______________________________________
_________________________________ _______________________________________
_________________________________ _______________________________________
_________________________________ _______________________________________

Would you be interested in a custom designed supplement program? Yes No
Would you be interested in a custom designed allergy elimination diet? Yes No
Would you be interested in a custom designed anti-aging hormone replacement program? Yes No

## Review of Systems

Please List any diseases and circle any of the below areas for which you have problems. Feel free to elaborate after each area.____________________________________________________________
______________________________________________________________________________

Head________________________________ Digestion / Bowels______________________________
Eyes_________________________________Bladder_______________________________________
Ears_________________________________ Brain or Nerves_______________________________
Nose and Throat_______________________ General Energy_______________________________
Breathing_____________________________ Female_______________________________________
Heart________________________________ Male________________________________________

***Overall feeling:*** How do you feel? This is an important question to ask of yourself. How do you feel today, yesterday, last week? When do you have your low moments? Is there a pattern? Is it hard for you to get out of bed in the morning (Y/N)?

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________________________________________________________________________________

________________________________________________________________________________

***Energy levels:*** How would you rank your energy level on a scale of 1 to 10? How has it changed in the last year?

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________________________________________________________________________________

***Schedule:*** How regular is your schedule of when you eat, exercise, and sleep? Is every day the same or different?

________________________________________________________________________________
________________________________________________________________________________

***Breathing:*** Anything abnormal to report (Y/N)? Do you hear or feel rattles when you breathe (Y/N)? Does it hurt to breathe deeply (Y/N)? Do you cough when you take a deep breath (Y/N)? Answer these questions for when you are at rest and after exercise.

________________________________________________________________________________
________________________________________________________________________________
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***Exercise tolerance:*** How much can you comfortably tolerate? How does this amount of physical activity compare with how you felt and how hard you moved your body last year? Does anything hurt or feel funny when you move or exercise (Y/N)?

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***Walking:*** Are you walking the same way you always have (Y/N)? Do you lean to one side and never did before (Y/N)? Do you hunch over more (Y/N)? Is it hard to walk fully upright (Y/N)?

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______________________________________________________________________
______________________________________________________________________

***Sensations:*** Anything unusual or out of the ordinary to report in any part of your body (Y/N)? For example, vision, hearing, smell? Is it as strong as ever? Weak?

______________________________________________________________________
______________________________________________________________________

***Skin:*** When you scan your skin for any strange marks, growths, or bumps while naked in front of the mirror, do you find anything (Y/N)? Has anything changed since the last time you examined your skin (Y/N)? Do your socks leave indentation marks on your ankles/legs (Y/N)? (If so, this could indicate that your heart isn't working properly and fluid is getting stagnant in areas, increasing your risk for a blood clot.)

______________________________________________________________________
______________________________________________________________________

***Hair:*** Has your hair changed at all in terms of thickness, texture, growth/loss, and so on (Y/N)? Have you lost hair around your ankles (Y/N)? This could be a sign of a circulatory problem, especially noticeable in men. Conversely, do you have hair growing in odd places, such as your arms and face (Y/N)? This could signal hormonal changes, especially in women.

______________________________________________________________________
______________________________________________________________________

***Nails:*** These dead tissues can actually tell you a lot. Have they changed in appearance or color lately (Y/N)? Discolored nails can signal certain conditions, from a simple infection to diabetes. If your nails have a yellowish hue to them, it's time for a diabetes check. Nails can also indicate iron levels. Look for a whitish crescent C at the base of your nails, which indicates good iron levels.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

***Joints:*** Do they hurt (Y/N)? More in the morning when you get up, or after a long day? What makes the aching joints better?

______________________________________________________________________
______________________________________________________________________

***Appetite:*** Is it the same as it used to be? Stronger? Weaker? Do you have serious cravings (Y/N)? If so, for what?___________________________________________________________________________

___________________________________________________________________________

***Breasts:*** If you're a woman, do you see or feel any lumps, bumps, or dimples when you perform a breast exam Y/N? Have you ever had a mammogram? Y/N Have You ever had a thermogram? Y/N

___________________________________________________________________________

___________________________________________________________________________

***Digestion:*** Any feelings of discomfort to report (Y/N)? Do you have to use any over-the- counter medications for your digestion/stomach on a regular basis (e.g., Tums, Pepto-Bismol, Tagamet, Zantac, Prevacid, laxatives, and the like) (Y/N)? If you have symptoms, are they better or worse after eating a meal? Do you experience an intolerance, sensitivity, or allergy to certain foods (Y/N)? Which foods?

___________________________________________________________________________

___________________________________________________________________________

***Headaches:*** Do you experience headaches regularly (Y/N)? Migraines (Y/N)? Do you know the triggers for such headaches (Y/N)? Do you find yourself taking over-the-counter painkillers consistently (e.g., Advil, Aleve, Tylenol, Excedrin, aspirin, and the like) (Y/N)?

___________________________________________________________________________

___________________________________________________________________________

***Allergies:*** Do you have any (Y/N)? Have your allergies changed over the years (Y/N)? How so?

___________________________________________________________________________

___________________________________________________________________________

***Sleep:*** Do you sleep well (Y/N)? Do you resort to sleep aids on occasion (Y/N)? Do you wake up feeling rested most of the time (Y/N)? How consistent are your bedtimes and wake times? Does your bed partner say that you snore (Y/N)?

___________________________________________________________________________

___________________________________________________________________________

***Pain:*** Is there any area where you feel discomfort or pain (Y/N)?

___________________________________________________________________________

***Immunity:*** Do you get sick a lot (Y/N)? How many fevers have you had this past year? When you get sick, does it seem to take you longer than your friends or family members to get better (Y/N)?

___________________________________________________________________________

___________________________________________________________________________

***Mood:*** How stable is your mood? Do you have feelings of depression (Y/N)?

___________________________________________________________________________

___________________________________________________________________________

***Hormonal cycle:*** If you're a woman, is your cycle regular (Y/N)? Are you in perimenopause or menopause?

___________________________________________________________________________
___________________________________________________________________________

***Previous diagnoses:*** What have you previously been diagnosed with? Is there anything that you deal with chronically (Y/N)?

___________________________________________________________________________
___________________________________________________________________________

***Stress level:*** On a scale of 1 to 10( 1 being minimal and 10 be extreme stress) , how do you rate your stress level_______? Is it chronic or just once in a while? Does the stress affect your lifestyle? If your stress is work-related, do you love or hate your job?___________________________________________________________________________

___________________________________________________________________________

***Weight:*** Are you happy with it (Y/N)? Have you tried to change it (Y/N)? What happened when you did? Do you have a paunch that you cannot get rid of (Y/N)?

___________________________________________________________________________
___________________________________________________________________________

***Health-care prevention:*** Are you up-to-date with things like routine exams/wellness checkups, screenings (e.g., Pap smear, colonoscopy, etc.), and blood tests (Y/N)? Do you know what foods you're supposed to be eating given your underlying disease risk factors (Y/N)?

___________________________________________________________________________
___________________________________________________________________________

***Overall satisfaction:*** If you had to rank how you felt about yourself in general, on a scale of 1 to 10, what would your number be? What kind of report card would you give yourself? What do you want to change in your life?

___________________________________________________________________________
___________________________________________________________________________

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# FINANCIAL POLICY, ASSIGNMENT & AGREEMENT

I, the undersigned, understand claims for services rendered will be submitted to my insurance company for payment. I understand that my health insurance is considered a method of reimbursing me for fees paid to Narberth Family Medicine and Acupuncture Center and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. Therefore, as my insurer may not cover all of the services necessary for my treatment I will be responsible to pay for and be financially liable for all applicable deductibles, co-pays and non-covered items as determined by my insurance carrier. Furthermore, if it is determined by the staff at Narberth Family Medicine that there is a patient copay(s) associated with any of the services provided to me I understand that these copay(s) are expected at the time services are rendered and will be paid by me at that time.
We are an osteopathic practice so each office visit will be billed to your insurance with two separate codes; one for the full exam and one for the osteopathic manipulation. You are welcome to decline the osteopathic manipulation at the start of your visit, however, please understand that this is our standard of care and if no mention is made the exam will include both services and be billed accordingtly.

Although Narberth Family Medicine and Acupuncture Center may **as a courtesy** convey to me information that it receives from my insurance company regarding the scope of my coverage I understand that Narberth Family Medicine and Acupuncture Center is not responsible to confirm or verify the scope of my coverage and cannot guarantee the accuracy of the information that it receives from my insurer. **I understand that both before and during the course of treatment I am responsible for understanding the scope of my insurance coverage, given that it does belong to me.** I am also aware that I should personally verify the scope of my insurance coverage with my insurer if I wish to have confirmation regarding the extent of insurance available for my treatment.

1. **I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize and assign Narberth Family Medicine and Acupuncture Center to release to Medicare and/or my insurance carrier and their agents any information needed to determine these benefits or the benefits for related services.**

2. **This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether paid or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.**

SIGNED (Patient or Parent if minor) ________________________________________

PRINT NAME ________________________________________

DATE _____/_____/__________

**Narberth Family Medicine and Acupuncture Center (NFMAC)**
**HIPPA - NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**NFMAC** is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

**<u>Disclosure of Your Health Care Information</u>**

**Treatment**

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

**Payment**

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

**Workers' Compensation**

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

**Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

**Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Change of Ownership**

In the event that **NFMAC** is sold or merged with another organization, your health information/record will become the property of the new owner.

**<u>Your Health Information Rights</u>**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **NFMAC** is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that **NFMAC** amend your protected health information. Please be advised, however, that **NFMAC** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by **NFMAC.**
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**<u>Changes to this Notice of Privacy Practices</u>**

**NFMAC** reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, **NFMAC** is required by law to comply with this Notice.

**NFMAC** is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

This notice is effective as of ______/______/_______

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide **NFMAC** with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____________________________________________

Patient's Name (print)

_____________________________________________ _____________

Patient's Signature Date