New Patient Intake Form

Full Name: _____ DOB: _____ SSN: _____

Gender : _____

Address: _____

City: _____ State: _____ ZIP : _____

Preferred Contact Method: Home Cell Work Other

Phone Number: _____ Email: _____ ◯ opt out of text/email

Marital Status: _____

EMERGENCY CONTACT

Name	Relationship	Phone	Release Info?
			YES / NO
			YES / NO

INSURANCE INFORMATION

Self Pay Active Insurance

Primary Insurance: _____ Effective Date: _____

Policy Holder Name: _____ DOB: _____

Member ID: _____ Group/Plan #: _____

Secondary Insurance: _____ Effective Date: _____

CARE TEAM INFORMATION

Specialty	Doctor's Name	Phone	Check if provider referred you
			☐
			☐
			☐
			☐
			☐
			☐
			☐

Preferred Pharmacy

Name / Address / Phone

ALLERGIES

Have you had allergy testing? YES / NO If YES, by whom?_____

Do you have pets in your home? YES / NO

Have you ever had birds, chickens or unusual pets? YES / NO

Please list ALL allergies

Allergy	Severity	Reaction	Treatment

MEDICATIONS

Please list ALL medications you are CURRENTLY taking. (Include all herbals, supplements, etc.)

Name	Dose	Frequency	Other Info

PAST MEDICAL & FAMILY HISTORY

Condition	Self	Relative	Relation to Patient	Onset Age	Age at Death
AIDS/HIV					
Acid Reflux (GERD)					
Allergies/Hayfever					
Anemia					
Arthritis					
Asthma					
Bleeding Disorder					
Blood Clot					
Bronchitis					
COPD					
Cancer					
Congenital Heart Disease					
Cystic Fibrosis					
Depression					
Diabetes					
Diverticulitis					
Emphysema					
Epilepsy/Seizures					
Fatigue					
Gout					
Heart Disease					
Hepatitis					
High Cholesterol					
Hypertension					
Kidney Disease					
Liver Disease					
Lung Mass					
Mental Illness					
Multiple Sclerosis					
Obesity					
Osteoporosis					
Over the counter medication					
Pneumonia					
Pulmonary Embolism					
Sinusitis (Sinus Infection)					
Sleep Apnea					
Stroke					
Thyroid Disease					

SURGICAL HISTORY

Surgery	Date	Hospital/Clinic	Complications

SOCIAL HISTORY

Diet and Exercise	
Do you have any dietary restrictions?	YES / NO
Do you engage in light exercise (e.g. light walking, housework, etc)?	YES / NO
Do you engage in moderate/ heavy exercise (e.g. brisk walk, jogging, strength training, etc)?	YES / NO
Substance Use	
Do you or have you ever smoked tobacco?	YES / NO
Do you or have you ever used any nicotine-free cigarettes, vape, or chewing tobacco?	YES / NO
Do you or have you ever used any other forms of tobacco or nicotine?	YES / NO
How many packs/day do you smoke?	
How many years have you smoked?	
Former smokers: How many years did you smoke, and how many packs per day?	
Has tobacco cessation counseling been provided?	YES / NO
What is your level of alcohol consumption?	None / Occasional / Moderate/ Heavy
Do you or have you ever used marijuana?	YES / NO
Do you use any illicit or recreational drugs?	YES / NO

What is your level of caffeine consumption?	None / Occasional / Moderate/ Heavy
Home and Environment	
Do you have any pets?	YES / NO
Are there any birds, chickens, or unusual pets?	YES / NO
Diet and Exercise	
Do you have moisture problems in your home?	YES / NO
Do you have smoke and carbon monoxide detectors in your home?	YES / NO
Are you passively exposed to smoke?	YES / NO
Are there any smokers in your house?	YES / NO
Have you been exposed to chemicals or toxins?	YES / NO
Have you been exposed to heavy metals?	YES / NO
Family	
What is your relationship status?	
How many children do you have?	
Are you currently pregnant?	YES / NO
Public Health and Travel	
Have you recently traveled abroad?	YES / NO
Advance Directive	
Do you have an advance directive?	YES / NO
Do you have a medical power of attorney?	YES / NO
Occupation	
Are you currently employed?	YES / NO

Patient's Printed Name: _____

Patient's Signature: _____ **Date:** _____

EPWORTH SLEEPINESS SCALE

First Name: _____ **Last Name:** _____

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

SITUATION	***CHANCE OF DOZING***
Sitting and reading	☐ 0 ☐ 1 ☐ 2 ☐ 3
Watching TV	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting inactive in a public place (e.g., theater or meeting)	☐ 0 ☐ 1 ☐ 2 ☐ 3
As a passenger in a car for an hour or more without a break	☐ 0 ☐ 1 ☐ 2 ☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting and talking to someone	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting quietly after lunch without a meal	☐ 0 ☐ 1 ☐ 2 ☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0 ☐ 1 ☐ 2 ☐ 3

Have you ever had a sleep study?	YES / NO
If yes, when and where?	
Do you sleep well at night?	YES / NO
Do you feel sleepy during daytime?	YES / NO
Do you snore?	YES / NO
Do you feel refreshed when you wake in the morning?	YES / NO
Have you been in a car accident or near miss situation due to falling asleep in the wheel?	YES / NO

CONSENT & RELEASE

Consent for Treatment

e at Nimbus Health. Services may include routine diagnostic pr
treatment. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by the physicians, advanced practitioners, and clinical and administrative support staff, as prescribed.

Notice of Patient Privacy Consent (HIPAA)

____ I have re itcceived a copy of the Healthcare Insurance Portability and Accountability act of 1996 (HIPAA) Notice of Privacy Practices. It provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. Patients can view the HIPAA Notice of Privacy Practices on our website at: nimbushealth.com/hipaa.

Terminating Services

____ Nimbus He itcalth providers work to build meaningful and productive relationships with our patients. Certain incidents and situations will require termination of the provider-patient relationship. Nimbus Health reserves the right to terminate the providerpatient relationship if and when the patient's actions negatively impact the provider's ability to treat and manage the patient's illness or pose a threat to practice operations. The following scenarios will lead to termination of the provider-patient relationship.

1. Three (3) missed/cancelled appointments in one year.
2. Non-Compliance with the treatment or management plan.
3. Rude, abusive behavior, use of obscene language, and mistreatment of staff in person or on the phone
4. Failure to pay a debt/account sent to collections.

No-Show Policy

____ I underst itcand and agree to Nimbus Health's no-show policy. If I am unable to attend a scheduled appointment, I will notify Nimbus Health at least one business day (24 hours) in advance to cancel or reschedule. Failure to provide timely notice will be considered a missed appointment. If I arrive more than 15 minutes late, I understand that I may need to be rescheduled to ensure fairness to other patients seeking care.

____ If I miss my appointment entirely, I agree to incur a $50 non-refundable no-show fee (alternatively a $25 fee for test-only visits or a $75 fee for test + exam visits), billed directly to me (not billable to insurance). Repeated missed appointments may result in limited scheduling options or dismissal from care. This policy is designed to promote fairness, as missed appointments limit access for other patients in need of care. Adequate notice allows Nimbus Health to offer those times to others.

Financial Policy

____ I understand that all applicable cost-sharing is due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Nimbus Health for services rendered. I authorize representatives of Nimbus Health to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. This includes any private insurance plans I may have, including Medicare Supplement Insurance (Medigap) plans.

Lifetime Medicare Authorization & Consent for Medicare Patients Only

____ I certify the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release any information needed for this or a related Medicare or Medicaid claim to the Social Security Administration or its intermediary carriers. I request that authorized benefits be paid on my behalf. I assign the benefits payable for Nimbus Health services. I understand that I am responsible for my health insurance deductible and coinsurance. *Please note that Federal Law requires us to bill our patients for their yearly deductible and coinsurance amounts, as determined by the insurance plan. We will bill your secondary insurance, if applicable, after Medicare pays the requested amount.*

Authorized Release of Medical Information

____ There are times where the physicians and employees of Nimbus Health need to contact you. Our primary method is phone calls; however, circumstances may require us to contact you by mail, email, telephone, voice mail, or text messaging. You may opt out of your authorized release at any time by mailing, calling, emailing, faxing or texting the practice. Consent for Use, Disclosure of Patient Information for the purposes of Treatment, Payment, and Healthcare Operations

____ I hereby consent to Nimbus Health using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out Nimbus Health's healthcare operations. I also consent to Nimbus Health using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information to another provider or health care entity for the purpose of conducting health care operations.

Health Information Exchange

____ Health information exchange enables health care providers to electronically share patient health information for several purposes, such as treatment, quality assuran

ce, and state law reporting requirements. I understand that if I go to Nimbus Health for treatment, the physicians and/or their staff may receive a copy of my medication history and other health care information electronically through various health information exchanges with other health care providers. I understand I may request that my health care information not be shared through electronic health information exchange by following the directions in Nimbus Health's Notice of Patient Privacy Practices.

Patient's Printed Name:_____

Patient's Signature:_____ **Date:** _____