Onyx Medical Practitioner PC
NuWave Medical PLLC

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P (631)343-7144 F (631)670-7035

NEW PATIENT INTAKE FORM

Weight Loss

PLEASE PRINT AND COMPLETE ALL ENTRIES

FIRST NAME	LAST NAME	DATE OF BIRTH
		_____/_____/_____

SEX	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS
❑ Male ❑ Female			

ADDRESS		
CITY	STATE	ZIP CODE

MARITAL STATUS	SPOUSES NAME	SPOUSE PHONE NUMBER
❑SINGLE ❑MARRIED		
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION

DO YOU HAVE INSURANCE?	PRIMARY CARD HOLDER	PRIMARY POLICY HOLDER NAME
❑YES ❑NO	❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	PRIMARY GROUP NUMBER
DO YOU HAVE SECONDARY INSURANCE?	SECONDARY CARD HOLDER	SECONDARY POLICY HOLDER NAME
❑YES ❑NO	❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	SECONDARY GROUP NUMBER

PAYMENT POLICIES

- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
- $50 No Show Fee for any Missed Appointment that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.
- $35 NSF charge for any returned check from the bank.
- If you are a private patient without insurance, all charges are due at the time of the visit.

PRESCRIPTION POLICY

PHARMACY NAME	PHARMACY PHONE NUMBER

- Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be Denied.

PATIENT SIGNATURE	**DATE**

PATIENT NAME: _____ DOB: _____

PATIENT MEDICAL HISTORY

Allergies

❑ NONE/Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Contrast ❑ Latex ❑ Morphine ❑ Penicillin

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid Disorder		

SOCIAL HISTORY

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No -** Do you smoke? ☐ Smoke (___packs per day) ☐ Chew
☐**Yes** ☐**No -** Do you drink caffeine? ☐ Daily ☐Weekly ☐Infrequently
☐**Yes** ☐**No –** Are you sexually active?
☐**Yes** ☐**No –** Do you wish to be checked for STDs?

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed
❑ Allergies
❑ Anemia
❑ Arthritis conditions
❑ Asthma
❑ Arterial fibrillation
❑ Bleeding problems
❑ BPH
❑ CAD coronary artery disease
❑ Cancer
❑ Cardiac arrest
❑ Celiac disease
❑ Chest pain
❑ Congestive heart failure
❑ Chronic fatigue syndrome
❑ Depression
❑ Diabetes
❑ Drug/alcohol abuse
❑ Erectile dysfunction
❑ Fibromyalgia
❑ Gerd
❑ Heart disease
❑ Hyperinsulinemia
❑ Hyperlipidemia
❑ Hypertension
❑ Hypogonadism male
❑ Hypothyroidism
❑ Infection problems
❑ Insomnia
❑ Irritable bowel syndrome
❑ Kidney problems
❑ Menopause
❑ Migraines/headaches
❑ Neuropathy
❑ Onychomycosis
❑ Organ injury
❑ Osteoporosis
❑ Pulmonary embolism
❑ Seizure disorders
❑ Shortness of breath
❑ Sinus conditions
❑ Stroke
❑ Syndrome X
❑ Tremors
❑ Wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

PATIENT NAME: _____ DOB: _____

Nutritional Evaluation:

Present Weight: _____ Height: _____ Desired Weight:_____

When would you like to be at your desired weight?

Why do you want to lose weight? (Health Benefit? Appearance?) Please explain thoroughly:

_____

_____

When did you begin gaining weight? _____ Reason why?
_____

What has been your maximum weight (non-pregnant) and when? _____

Have you tried other weight loss programs? Yes No
If yes, which ones? _____

Were you successful with it / were you able to keep the weight off? Yes No Please explain: ___
_____

Is your spouse, fiancée or partner overweight?
Yes No
By how much is he/she overweight? _____

How often do you eat out? _____

What restaurants do you frequent? _____

How often do you eat "fast foods"? _____

Food allergies? _____

Food dislikes? _____

Activity Level: (check one)

_____ Inactive
_____ Light Activity
_____ Moderate Activity
_____ Heavy Activity
_____Vigorous Activity

On a scale of 1 to 10 with 10 being **MOST** committed, how committed are you to taking action and making a change in your life today? 1 2 3 4 5 6 7 8 9 10

Notice of Privacy Practices
Onyx Medical Practionier PC
NuWave Medical PLLC

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. It also discusses the uses and disclosure we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of the notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy policy notice from the Practice's Privacy Officer.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

By the law, consent is not required to discuss your medical treatment with your other doctors or healthcare providers. This also allows for a prescription to be called into your pharmacy. Additionally, none is needed in the course of carrying out healthcare operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.

However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent. Specific authorization is required to disclose protected information in non-routine circumstances, such as your employer or for use in marketing a product to you.

Medical information about you may be released for research and public health uses, as long as you are not individually identified.

We may contact you to provide appointment reminders for treatment or medical care, and also to recommend possible treatment alternatives or other health-related benefits and services that may be if interest to you.

You have the right to review when and to whom your information was released.

You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.

Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you to, this office or the Secretary of Health.

This law requires that you acknowledge receipt of this notice; this has been included on the signature release on the bottom of this form.

You have the right to inspect and copy your health information; you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

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I acknowledge that I have read and understand the above Notice of Privacy Practices.

Signature: _____ Date: _____

Relationship to Patient: _____