GhentMD
INTEGRATIVE HEALTH & WELLNESS CLINIC

New Patient Intake Form

Patient demographics
*Last name:_____ *First name:_____
DOB:_____/_____/_____ *Legal Sex:_____
Home Address:_____ Apt #_____City:_____
Zip Code:_____
Best contact number:_____Email:_____
***May we leave a detailed voice message?** □Yes □No

Primary Language: □English □Spanish □Other_____

Insurance Information
Insurance name:_____
Member ID #:_____ Group #:_____
Payer Address (Insurance):_____ City:_____
Zip Code:_____

Insured person
□ Same as patient
Patient Relationship:_____
First name: _____ Last name: _____
DOB:_____/_____/_____ Sex: _____
Address:_____ Apt #_____City:_____
Zip Code:_____

Occupation:_____
Employer:_____

***Preferred Pharmacy**:_____
Pharmacy phone number:_____
Pharmacy Address or cross streets:_____

Emergency Contact
Name:_____Relationship:_____
_Emergency Contact Phone: _____

Advance Directives:(do you have one of the following?) □None □HC Proxy □Living Will □ DNR
Do You want Cardiopulmonary resuscitation (CPR): □Yes □No

Reason for today's visit? _____

Drug/food allergies

Do you have any allergies to the following (select all that apply)

□Latex □Medications □Food □I.V. Dye/contrast □ Adhesive Tape □Environmental □None

*If yes to any of these please list allergen and reaction(s) like rash, hives, throat swelling, anaphylaxis.

Allergen	Reaction

Please list current Medications & Supplements you take, along with the strength and amount you take daily.

Medication Name	Strength	Quantity taken daily	Do you need a refill
			□Yes □No
			□Yes □No
			□Yes □No
			□Yes □No
			□Yes □No

Supplement Name	Strength	Quantity taken Daily

Risk Factors

Do you use tobacco: □Yes/Current □No/Never □Former **If former:** Year Quit? _____

If yes what type**:** □Chewing □Cigarettes □Pipe □Vape

Packs a day? _____ Years Used? _____

Secondhand smoke Exposure □ Yes □No

Would you like information from the Ash Hotline to help reduce/Quit smoking: □ Yes □ No

Drug use: □Yes □No If yes what type_____

Do you consume Alcohol: □Yes □No □Former

If yes, what type: □Beer □Wine □Liquor

Frequency: □Rarely □Frequently □Social □Occasional □Daily

Drinks per week? _____

Do you consume Caffeine daily: □Yes □No

If yes, what type: □Coffee □Energy Drinks □Soda □Teacups

Drinks per day? _____

Social History

Relationship Status: □ Single □ Life partner □ Married □ Divorced □ Widowed.

Are you Sexually active: □Yes □No

Number of partners in the last year: _____ □ Men □ Women □Both

Do you want STD/STI Testing: □Yes □No

Race

□ White □Black/African American □Hispanic/Latino □American Indian/Alaska Native

□Asian/Pacific Islander/Native Hawaiian

□Decline to answer

Do you follow a specific Diet (select all that apply)?
□Diabetic □Low Carb □Low Fat □Low Chol □Low Salt □No Added Salt □No Specific Diet □Regular □Renal □Vegetarian □Weight Loss □Keto □Other_____

Activity Level
□Sedentary □Occasionally □Regular □Active lifestyle □Physically unable to exercise

Exercise Type (select all that apply)
□Aerobics □Cycling □Dancing □Elliptical □Jogging □Physical therapy □Running □Swimming □Team sports □Walking □Weightlifting

Family History
□Unknown family history □Adopted (unknown) family History

Family	Age	Age at Death	Cause Death	Diagnosis	Diagnosis	Diagnosis
Mother						
Father						
Brother						
Sister						
Child						
Other						

Past Medical History (You have been diagnosed by a provider even if resolved)
Please select all conditions that apply:
□COPD □Sleep Apnea □Asthma □Hypothyroidism □Obesity □Cancer, Type: _____
□Arrhythmias □Coronary artery disease (CAD) □Heart Attack □DVT □Hypertension □Diabetes Mellitus
□High Cholesterol □Reflux esophagitis (GERD) □Vitamin D deficiency □Arthritis, Type: _____
List any other medical conditions you have been diagnosed with: _____
List any Surgeries or Procedures you have had in the past: _____
Recent hospitalizations? If yes, please explain: _____

Female Questions
Date of last menstrual cycle_____ Abnormal bleeding □Yes □No Painful Periods □Yes □No
Date of last Pap smear_____ Date of last Mammogram_____
Are you on Birth control □Yes □No Are you: □Premenopausal □ Menopause □Postmenopausal?
Have you had a Hysterectomy □Yes □No If yes, what type: □Full □Partial?
Number of Pregnancies: ____ Live Births: ____ Miscarriages:____ Abortions:____

Review of symptoms (ONLY SELECT THE PROBLEMS YOU ARE CURRENTLY EXPERIENCING)
□Fever □Fatigue □Chills □Sweats □Sleep disturbances □Itchy Eyes □Runny nose □Depression
□Neck stiffness □Congestion □Sore throat □Chest pain □Palpitations □PTSD
□Leg Swelling/Edema □Leg Pain w/Walking □Irregular heart rhythm □Shortness of breath □Anxiety
□Coughing up sputum □Chest congestion □Wheezing □Abdominal pain □Diarrhea □Blood in stool □
Black/Tarry stools □Vomiting □Decreased appetite □Bowel incontinence □Nausea □Constipation □Headache
□Dizziness □Decreased strength □Poor circulation □Unsteady/Loss balance □Confusion □Disorientation □Burning sensation □Numbness □Tingling □Seizures □Fainting (Syncope) □Tremors □Memory loss/lapses □Joint Pain
□Neck Pain □Back pain □Limb pain □Joint swelling □Muscle cramp □ Muscle pain □
Frequent urination □Urinary incontinence □Urinary urgency □Painful urination □Pelvic pain □Change in libido.
□Painful intercourse □Vaginal discharge □Vaginal bleeding □Rash □Dry skin □Skin wound □Unusual Growth

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Health Screening Questions

Immunization record

Vaccine	Date (Year)	Vaccine	Date (Year)
□ Influenza		□ Pneumococcal	
□ Hepatitis A		□ Tetanus	
□ Hepatitis B		□ DTAP	
□ Shingles			
□ MMR			
□ Other			

Age related screening record

Test	Date (Year)	Normal	Abnormal
Colonoscopy		□	□
Stool Cards		□	□
Pap Smear		□	□
Mammogram		□	□
Bone Density		□	□
PSA		□	□

NEW PATIENT CONTRACT

Thank you for choosing to obtain your healthcare at GHENTMD. We are committed to providing you with high quality care. Please read this contract, ask us any questions you may have, and sign in the space(s) provided. A copy will be provided to you upon request.

GENERAL CONSENT TO TREATMENT: I request and authorize GHENTMD healthcare providers, assistants, or designees to provide routine medical care to myself or the person for whom I am guardian. I understand that I have the right to ask the healthcare providers any medical or healthcare related questions. I will follow all treatment and post treatment instructions as explained and directed to me by healthcare providers. I acknowledge that no guarantees or promises have been made to me with respect to the results of diagnostic procedure or treatment.

INSURANCE POLICIES, FEES & PAYMENTS: GHENTMD will submit claims on your behalf to insurance carriers with which we participate. At GHENTMD, we are dedicated to high quality care and go beyond the standard medical care to our patients. Forms of payment accepted include cash, check, major credit cards and payment plans. Comprehensive physicals, certain laboratory tests, procedures, and recommended medications including nutritional supplements may not be covered. When indicated, prior authorizations may be completed at the discretion of our providers. We cannot guarantee that all services and therapies we provide or recommend are covered by your insurance. We strongly encourage you to contact your insurance carrier ahead of time and verify appropriate coverage. It is your responsibility to know your insurance plan benefits. Billing your insurance does not necessarily guarantee payment by the insurance company nor does it release the responsible party from its financial obligation to GHENTMD for any unpaid balance. In case of an insurance partial payment, the balance is due by you and we will send you a billing statement. GHENTMD is not responsible to negotiate a settlement for a disputed claim. I understand that all applicable copays and deductibles are 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 GHENTMD for services rendered. I authorize representatives of GHENTMD to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. Cash or Self-Pay Patients: All payments are to be paid at the time of services. You are a cash or self-pay patient until you submit active insurance cards, and GHENTMD qualifies and accepts your insurance coverage. Please note, if your account with GHENTMD is delinquent more than 120 days and no payment arrangement has been established, we may involve a collection agency to recover the full amount owed. A re billing fee of $20 will be charged for all re billing. For accounts placed in collection, a $50 additional charge will be placed. Any check returned for non-payment will generate an additional processing fee of $40.

NON-COVERED SERVICES: Please be aware that any services considered to be a non-covered benefit by your insurance will be your financial responsibility.

PROOF OF INSURANCE: Please provide us with all necessary information about your insurance, both primary and secondary. We must obtain proof of current insurance and a photo ID at check-in for every visit.

MISSED AND LATE APPOINTMENT POLICY: I understand that if I am unable to make a scheduled appointment, I need to contact the office at least 24 hours before my scheduled appointment time. A $50 fee will be billed directly to you for missed appointments not cancelled within at least 24-hour advanced notice. This fee is not covered by your insurance and must be paid prior to your next appointment. Multiple “no shows” in a 12-month period may result in termination from our practice. Please help us serve you better by keeping your scheduled appointment. If a patient is 15 minutes past their scheduled time, we may have to reschedule the appointment. I also understand that if I am late for my appointment, I may not be seen that day and may need to reschedule. Please call the office at (480)-935-8855 if you are running late.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been provided with a Notice of Privacy Practices (NOPP) that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I accept that I can request a copy of the NOPP at any time and the NOPP is posted in the office and online at https://ghentmd.com/

PERSONAL AND MEDICAL INFORMATION: I have provided an accurate and complete personal and medical history, including social history, family history, allergies, medications, and supplements I am currently taking. It is my responsibility to give updated personal and medical information to GHENTMD if any changes occur.

REFERRALS – If your provider recommends referral to a specialist or for diagnostic testing that requires a referral, we will ensure that this occurs as soon as possible. Some referrals are contingent on the review of your medical records and/or the booking capacity of the specialist's office. Occasionally, referrals cannot be immediately processed because they require insurance prior authorization. New requests for referrals require an evaluation visit with a provider.

MEDICATION REFILL POLICY – Medications will be prescribed with enough refills until you are due for a follow up visit to reassess the condition and applicable medication. It is your responsibility to make a follow up appointment for medication refills before you run out. We recommend routine follow up visits at least every 6 months, depending on your medical condition. Medication refill requests may be sent electronically, or faxed to GHENTMD at 855-450-1054, by your pharmacy. Please note that medication refill requests may take up to 3 days to process, therefore, plan accordingly.

CONTROLLED SUBSTANCE POLICY – All controlled substances require an office visit. We participate in the Arizona Prescription Monitoring Program. Should opioids be deemed necessary following clinical review, they will be prescribed for no longer than FIVE (5) days for the management of acute pain. For chronic pain management, except in a few instances and at the discretion of the provider, a determination for ongoing care and need for opioid prescription is made on a case-by-case basis and according to clinical guidelines. A Pain Management Contract is required for chronic pain management. Refills on all DEA Schedule II medications including narcotics (opioids) and certain stimulant medications require monthly visits. This is due to the potential for abuse, safety concerns and risk of dependence on these medications.

FORM COMPLETION POLICY – Forms requiring medical review and physician signature including FMLA paperwork, Short Term Disability, and certain miscellaneous patient requests require an office visit. During the visit, an assessment for referral to a specialist(s) for further evaluation and management may be determined. Forms when completed will be made available to you in 5 business days. Please note, we do not perform or complete Long-Term Disability Forms and Evaluations. For the completion of forms or writing of letters not related to a scheduled office visit, GHENTMD will charge an administrative fee.

REQUESTS FOR MEDICAL RECORDS – Requests for medical records will be honored only when accompanied by a properly filled/signed records release form. Medical records released to a specialist, new provider or school for care continuity will be forwarded at no charge. Medical records released to the patient, law firm, some insurance companies or miscellaneous agencies, are subject to copying fees. Please allow up to 7 business days for processing of requested medical records.

AFTER HOURS – Please utilize our regular office hours for appointment scheduling, prescription refills and management of non-emergency medical conditions. In an afterhours emergency situation, call the office number 480-935-8855, and you will be directed to the on-call provider's service number. Kindly note that after regular hours we will not call-in medication refills or antibiotics. No controlled substance medications will be called in after hours.

REPORTS OF TESTS- If test results are normal, we will notify you over the phone. Should test results be abnormal, we may call you over the phone to inform you. Please note however that certain abnormal test results will require you to set up a visit as these may require further testing, reassessment and/or diagnostic or specialist referrals.

IN ANY LIFE-THREATENING SITUATION, PLEASE CALL 911 IMMEDIATELY.

I have read and understand all the above (Consent to treat, Insurance, Payments, Fees, Non covered services, Proof of insurance, Missed and late appointment, Notice of privacy practices, Personal and medical information, Referrals, Medication refill, Controlled substance, Form completion, Medical records, After hours, Reports of tests).

Patient or Legal Guardian Name (PRINT)_____

Patient SIGNATURE_____Date_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that in any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.
Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother' s expected child or children. Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.
Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing-the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Arizona Revised Statutes (ARS) 12-1501-12-1518 and the Federal Arbitration Act (9 U.S.C 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fee and expenses.
Article 4: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.
Article 5: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona and federal law.
I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy of this agreement. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION (Anthony Aghenta, MD; Rita Aghenta, pharmD; GHENTMD and its agents; or employees of all above named entities) AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT*

I have read and agree to all the above (Physician-Patient Arbitration Agreement).

Patient or Legal Guardian Name (PRINT):_____

PATIENT SIGNATURE_____ Date_____