Live Oak Medicine

Carmen Hering, DO

902 Santa Fe Avenue, Albany, CA 94706

(510) 526-5256 • fax (510) 526-5547

www.carmenheringdo.com

liveoakmed@gmail.com

NEW ADULT PATIENT INTAKE FORM

Today's Date: _____

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

Address(s):

_____

_____

Home Phone(s): _____ Work Phone(s): _____

Cell Phone(s): _____ Email Address(s): _____

Best place(s) to leave messages: ☐ Home ☐Work ☐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: _____

Duration of problem: _____

ADULT HEALTH QUESTIONNAIRE

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

Allergies (drugs, foods, environmental):

_____

_____

Healthcare Practitioner(s) from whom you are *currently* receiving medical care:

Physician/ Practitioner	Condition being treated	Medications/Supplements

Past Surgical Procedures	Date	Reason performed

ADULT HEALTH QUESTIONNAIRE

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 ankle
  - ☐irregular pulse
  - ☐palpitations
- ☐ Leg pain when walking
- ☐ Varicose veins / Phelebitis
- ☐ Cold numb feet
- ☐ Loss of appetite - recent
- ☐ 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
  - ☐with leakage
- ☐ Decrease in force/flow ☐painful
- ☐ Stress incontinence – urine leakage with exercise /movement
- ☐ Blood in urine ☐Kidney stones
- ☐ Urine infections – frequent
- ☐ Sexually transmitted diseases
- ☐ Sexual problems
- ☐ 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
- ☐ Foot pain ☐Gout
- ☐ Rashes ☐Hives
- ☐ Psoriasis ☐Eczema
- ☐ Any type of sleeping difficulty
- ☐ Depression ☐Nervousness
- ☐ Agitation ☐Memory loss
- ☐ Moodiness ☐Suicidal thoughts
- ☐ Phobias ☐Mental illness
- ☐ Feelings of worthlessness
- ☐ Rheumatic fever ☐Scarlet fever
- ☐ Chickenpox ☐Polio ☐Mumps
- ☐ Measles ☐German measles
- ☐ Tuberculosis ☐Herpes
- ☐ AIDS / HIV

- ☐ Alcohol _____ oz per week
- ☐ Coffee / Tea _____ cups per day
- ☐ Smoking _____ cig/day
  # years _____ year quit_____
- ☐ Exercise _____
- ☐ Street drugs _____
- ☐ Acupuncture / tattoos
- ☐ Hair loss
  - ☐progressive ☐recent

MALES: ☐ Prostate problems

FEMALES *Please complete:*

Menstrual Flow:

- ☐ 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 _____

Abortions _____

Miscarriages _____

Live Births _____

Birth control method

_____

☐ Flushing / Menopause

Date of last PAP test _____

☐ Normal ☐ Abnormal

Date of last mammogram _____

☐ Normal ☐ Abnormal

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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 2-business day cancellation policy. If you cancel an appointment less than 2-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 refrain 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.
Dr. Hering is not a contracted provider with Medicare, therefore Medicare beneficiaries are not allowed to submit claims to Medicare for reimbursement. If you have Medicare, please read and sign our Medicare Beneficiary Agreement.

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: 10/01/2024

(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 Carmen Hering 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 - ACKNOWLEGEMENT 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: _____

Patient/Guardian Signature: _____ _____

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MEDICARE BENEFICIARY AGREEMENT

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

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

2. 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.

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

4. 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.

5. 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/Guardian Signature: _____ _____

Date

_____