5765 S. Rainbow Blvd, Ste. 111
Las Vegas, NV 89118
P: 725-726-7914 | F: 504-370-5627

Primary Care Patient Intake Form

Full Name: _____

Date of Birth:_____/_____/_____

Social Security #:_____-_____-_____

Gender: ☐ Male ☐ Female ☐ Other

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: (_____) _____-_____

Email Address: _____

Emergency Contact: _____

Relationship: _____

Phone Number:(_____) _____-_____

Insurance Information

Primary Insurance: _____

Policy Number: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's Date of Birth: __/__/____

Relationship to Patient: _____

Do you have Secondary Insurance?

If Yes: _____

Medical History

Primary Care Physician: _____

Phone Number: (_____)_____-_____

Date of Last Physical Exam: ____/____/____

Medical Conditions (Check all that apply)

☐ Diabetes
☐ Hypertension
☐ Heart Disease
☐ Asthma
☐ COPD
☐ Cancer
☐ Stroke
☐ Arthritis
☐ Osteoporosis
☐ Thyroid Disorder
☐ Kidney Disease
☐ Liver Disease
☐ Seizures
☐ Depression
☐ Anxiety
☐ Other: _____

Surgeries (Please list all surgeries and dates)

1. _____ Date: __/__/____
2. _____ Date: __/__/____
3. _____ Date: __/__/____

Allergies (Check all that apply)

☐ No Known Allergies
☐ Medications: _____
☐ Foods: _____
☐ Environmental: _____
☐ Other: _____

Family Medical History (Check all that apply)

☐ Diabetes
☐ Hypertension
☐ Heart Disease
☐ Cancer
☐ Stroke
☐ Other: _____

Social History

Tobacco Use: ☐ Never ☐ Former ☐ Current
Alcohol Use: ☐ Never ☐ Socially ☐ Frequently
Drug Use: ☐ Never ☐ Former ☐ Current

Occupation: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Children: ☐ Yes ☐ No If yes, how many? _____

Pharmacy Information

Please provide the details of your preferred pharmacy. This information will help us send your prescriptions directly to your pharmacy for your convenience.

Pharmacy Name:_____

Pharmacy Address:_____

City:_____

State:_____

Zip Code:_____

Pharmacy Phone Number:_____

Pharmacy Fax Number (if available):_____

Review of Systems (Check all that apply)

General:
☐ Weight Loss
☐ Weight Gain
☐ Fatigue
☐ Fever

Cardiovascular:
☐ Chest Pain
☐ Palpitations
☐ Shortness of Breath

Respiratory:
☐ Cough
☐ Wheezing
☐ Shortness of Breath

Gastrointestinal:
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation

Musculoskeletal:
☐ Joint Pain
☐ Muscle Pain
☐ Back Pain

Neurological:
☐ Headaches
☐ Dizziness
☐ Numbness

Psychiatric:
☐ Depression
☐ Anxiety
☐ Insomnia

Medication List

Please list all prescription medications, over-the-counter drugs, vitamins, supplements, and herbal remedies you are currently taking.

Medication Name	Dosage (mg, units, etc.)	Frequency (daily, weekly, as needed, etc.)	Reason for Use	Prescribing Physician

Allergies & Reactions

Do you have any allergies to medications?

☐ **No**

☐ **Yes** (If yes, please list below)

Medication Name	Reaction (e.g., rash, swelling, anaphylaxis, nausea, etc.)

Consent to Treatment in a Teaching Institution

Welcome to NuThera. We are a teaching institution committed to providing high-quality care while training the next generation of healthcare professionals. This means that students, including Physician Assistant (PA) students, may assist in your treatment under the supervision of a licensed physician (MD) or physician assistant (PA).

Supervision Details:

- All student activities are supervised by a licensed MD or PA.
- The supervising MD or PA is on-site and readily available to provide guidance and support.

Patient Consent: By signing this form, you acknowledge and consent to the involvement of students in your care. If you do not wish to be treated by a student, please indicate your preference below.

Consent Agreement:

I consent to receive treatment from students under the supervision of a licensed MD or PA.

Signature_____ Date_____/_____/_____

Non-Consent Agreement:

I do not consent to be treated by students and wish to be seen only by trained kinesiotherapist, PT, chiropractor, PA, or MD.

Signature_____ Date_____/_____/_____

Thank you for your understanding and cooperation. Your decision will not affect the quality of care you receive at NuThera.

Consent toTreat and Consent to Bill Insurance Form Patient Information:

Full Name:_____Date ofBirth:_____/_____/_____

Address:_____

City:_____ Zip Code: _____

Phone Number:_____-_____-_____

Email Address:_____

Consent to Bill insurance

I hereby authorize this facility to bill my insurance company for the services provided to me. This includes billing Medicare, Medicaid, private insurance, and the Department of Labor, as applicable. I understand that I am responsible for any charges not covered by my insurance, including copayments, deductibles, and non-covered services

Primary Insurance Name: _____

PolicyNumber:_____

Group Number. _____

Subscriber's Name_____

Subscriber's Date of Birth:_____/_____/_____

Consent to Treat

I hereby consent to the evaluation and treatment of my medical condition by the healthcare providers at this facility. This may include diagnostic tests, procedures, medications, and other treatments deemed necessary by my healthcare providers. I understand that I have the right to ask questions and discuss my treatment options with my healthcare providers.

Patient Signature:_____ Date:_____/_____/_____

Guardian Signature (If applicable):_____

Relationship to Patient_____

CONSENT FORM FOR SMS TEXT MESSAGING

Patient Name:_____Date of Birth:_____/_____/_____

I,_____ (Patient'sName), hereby consent to the use of SMS text messaging as a method of communication for administrative and clinical purposes by NuThera, medical practice. I understand that

1. SMS text messaging is not a completely secure medium and privacy cannot be ensured. NuThera, medical practice is not responsible for any loss, harm, or damage that may arise from this method of communication.
2. I may revoke this consent at any time by providing written notice to NuThera, medical practice.
3. Message and data rates may apply depending on my mobile carrier and plan.
4. I can opt out of SMS text messaging at any time by replying STOP to any received message.
5. The following types of information may be communicated via SMS text messages: appointment reminders, billing information, test results, and general health reminder information.

By signing this form. I acknowledge that I have read, understood, and agree to the above terms.

Patient Signature_____Date:_____/_____/_____