New Client Intake Form

Title (circle one): Mr. Mrs. Ms. Other: _____

First Name: _____ Middle Initial: ____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Leave Messages on (circle one): Home Cell Work Don't Leave Messages

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Date of Birth: _____ Sex: Male Female

Social Security Number: _____ Marital Status (circle one) Single Married Other

Employment Status

(circle one) Employed Unemployed FT Student PT Student Other

Employer Date: _____

Employer: _____

Occupation: _____

Emergency/Significant Contact

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Primary Insurance: _____ ID #: _____ Group #: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Pharmacy: _____ Phone #: _____ Pharmacy Benefits: _____

INFUSE by Vibra™

Health History Intake Form

Name of referring physician/Specialist: _____

Most recent physical exam: _____

Medical History (check all that apply)

AIDS/HIV ☐
Alcoholism ☐
Alzheimer's ☐
Anemia ☐
Rheumatoid Arthritis ☐
Asthma ☐
Blood clots ☐
Stroke/ TIA ☐
Bone infections ☐
Osteoporosis ☐

Cancer ☐
COPD/lung disease ☐
Depression ☐
Diabetes ☐
Drug Abuse ☐
Sleep Apnea ☐
Thyroid problems ☐
Gout ☐
Heart Disease ☐
High blood pressure ☐

Migraine headaches ☐
Kidney Disease ☐
Hepatitis/Liver Disease ☐
Tuberculosis ☐
Seizures ☐
Ulcers, bleeding ☐
Blood thinners ☐
Osteogenesis Imperfecta ☐
Osteoarthritis ☐
Other disease(s) ☐

Do you smoke? _____ Do you drink alcohol? _____

Females Are you pregnant? _____ Last menstrual period _____ Birth Control _____

Hysterectomy _____ Menopause _____

Allergies: _____

Surgeries: _____

Other pertinent health history: _____

By signing below, I acknowledging that the information provided above is current and correct.

Signature _____ Relationship (if not parent) _____

INFUSE by Vibra™

Medicine List

Medication	Dose	Time	Food	Reason	Doctor

Healthcare Information Patient Privacy Form

Release of Information

Patient: _____ Date: _____

By initialing and signing below, I agree to the following:

1. Authorization to release Information: _____ I hereby authorize Infuse by Vibra to release any information acquired in the course of my examination and treatment to my referring physician or family member(s) listed below.

   _____ _____ _____

2. Authorization to obtain prior studies/pertinent information: _____ I hereby grant authorization to Infuse by Vibra to request prior medical records/reports pertaining to this visit from my referring physician.
3. Assignment of Benefits: _____ I hereby authorize payment to Infuse by Vibra all benefits due by reason of the services described in this statement. I will be responsible for any balance in whatever excess of whatever sums may be paid by my insurance company.
4. Acknowledgment of HIPPA/Privacy Notice: _____ I acknowledge that the privacy notice has been made available to me.

Signature: _____ Date: _____