Patient Intake Form

Name _____ Date _____

First Name _____ Last Name _____

Address Line _____

City _____ State _____ Zip Code _____

Occupation _____

Referred by: Lynn Hege, LME

Emergency Contact: _____

Home Phone (____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email

Sex: Male Female

Insurance Information
Subscriber Name & ID Number- _____ DOB: _____. Group Number: _____

Health Concerns in order of importance:

1. _____ 2. _____ 3. _____

How did you hear about our office: Lynn D. Hege, LME

Current Physicians

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Medical Problems: _____

Allergies: _____

Other/Medications/Supplements: _____

Other Comments _____

BETTER CARE
CONCIERGE MEDICINE

Phillip M. Hobbs, MD
Michael S. Diamond, MD
Landon T. Williams, MD
Lynn D. Hege, LME

GENERAL CONSENT FOR CARE and TREATMENT CONSENT

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indication that (1) you intend that this consent is continuing in nature even after specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test order for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or clinical Nurse Specialist), and other health care providers, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient Name _____

Patient Date_____