# New Patient Information
# Olive Tree Place Inc.

**Patient Name:** _____

Address: _____

City_____ State_____ Zip_____

Home Phone#_____ Cell Phone #_____
Please circle the phone number you wish to be used for scheduling changes or cancellation.

May private information be left at this number? _____yes _____No

Date of Birth_____ Age_____ Gender: _____

Marital Status_____ Spouse Name_____

**In case of emergency notify**_____ Tele:_____

*****If patient is a minor**

Parent / Guardian Names _____

**INSURANCE (we will need a copy of card)**

Insurance Company_____ **or** Cash Pay_____

Name of Policy Holder_____ Male Female

Relationship to Patient_____

Birth Date_____ Phone Number_____

Address_____

City_____ State_____ Zip_____

**Bill balance to**: _____

City_____ State_____ Zip_____

Telephone number: _____

**Would you like a text reminder for your appoints?**

Cell number_____

**Cell carrier** (ATT, Verizon…) _____Cell phone must be turned on for messages to be received. Do not reply to texts- they are an automatic software function and are not answered or seen.

- **Assignment of benefits to insurance:**
  I authorize payment of medical benefits to the named provider for professional services rendered.
- **Release of Information:**
  I authorize the release of any information necessary to process insurance claims.

Signed _____ Date _____

- **Consent for Treatment**
  I agree to receive mental health treatment from Olive Tree Place, Inc., and Laura Hawkins MS, MSN, CNS, NCC. I agree to ask any questions I may have about the risks, alternatives, and benefits of treatment.
- **Financial Responsibility**
  I accept financial responsibility for any and all charges for medical services provided. My insurance will be billed as a courtesy. I accept responsibility for any amount not covered by insurance. This includes any fee for canceled or missed appointments which are less than 24-hr notice.
- **Office Policies**
  I have read, understand, and agree to the Office Policies handout.
- **Notice of Privacy Practices and Patient Rights**
  I have been offered a copy of the Notice of Privacy Practices and Patient rights document.

Signed_____ Date _____

- **Consent for treatment of children and adolescents**

  I / we consent that _____
  may be treated as a patient by Laura Hawkins, CNS-BC, NCC.

  Signed_____ Date_____

Reason (symptoms) for today's appointment_____

Primary Care MD or NP_____ phone # _____

All previous surgeries and approximate date: _____

_____

Illnesses and conditions which are currently being treated or have been treated in the past:

_____

_____

_____

**Children only**: Birth weight? _____ Healthy at birth? _____

Developmental milestones met at expected time? (explain any abnormalities)

_____

**Medication Allergies**_____

Current medications and dosages:

_____ _____mg times per day_____

_____ _____mg times per day_____

_____ _____mg times per day_____

_____ _____mg times per day_____

_____ _____mg times per day_____

_____ _____mg times per day_____

_____ _____mg times per day_____

_____ _____mg times per day_____

_____ _____mg times per day_____

**Circle any symptoms you are currently experiencing or have experienced in the past:**

| | |
|---|---|
| Constitutional | chills fever weight loss weight gain tiredness<br>appetite changes |
| Eyes | blurred vision eye pain eye discharge |
| Ear, Nose, Mouth Throat | ear pain difficulty swallowing sore throat nose drainage |
| Cardiovascular | chest pain palpitations high/low blood pressure Varicose veins swelling of ankles/legs |
| Respiratory | asthma cough shortness of breath wheezing |
| Gastrointestinal | nausea vomiting bloating stomach pain constipation<br>diarrhea change in bowel habits |
| Genitourinary | painful urination blood in urine kidney/bladder infections<br>increased/decreased urination |
| Musculoskeletal | arthritis joint pain/aches/stiffness gout muscle pain<br>muscle weakness |
| Integumentary (Skin) | hives redness lumps wounds rashes bruising<br>Change in nail/hair texture |
| Neurological | blackouts dizziness fainting headache loss of balance<br>loss of coordination loss of sensation numbness seizures<br>concussion |
| Endocrine | diabetes hot flashes low sugar thyroid condition<br>excessive hunger/thirst |
| Hematologic<br>Lymphatic | Swollen glands/nodes nosebleed bruising |
| Immunologic | Fibromyalgia lupus rheumatoid arthritis<br>Other autoimmune disorder:_____ |