Holley A Dagenhardt, MA, RD, LDN
Member Health Partnerships Provider

Last Name: ______________________ First Name: ____________________________ MI __________

Birth Date (m/d/y): ________________________ Sex: ☐ Male ☐ Female

Patient Address: _____________________________________ City: ______________________________

State: ______ Zip: __________ Telephone: Home / Work / Cell ______________ E-Mail Address: __________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Marital Status: ☐ Single ☐ Married ☐ Other

Employment: ☐ Employed ☐ Full Time Student ☐ Part Time Student

Employer/School Name: ____

Family Doctor: ____________________________ Doctor Phone #: ________________________

Emergency Contact: ____________________________________ Number: ___________________

Insurance Agreement (does not apply to self pay patients)

The following contains information required by Holley Dagenhardt in order to bill the patient's insurance carriers. I understand that I am financially responsible for any charges not paid by insurance carriers. The filing of claims is performed as a courtesy only.

____________________________________ ___________
Signature Date

Primary Insurance: _____________________ Policy Holder Name: ______________________________

Group Number: _____________________ Subscriber ID: ______________________________

Please tell us who referred you: ____

Acceptance of Assignment of Insurance Claims

I authorize D&A to submit insurance claims to my insurance carrier on my behalf, and I authorize my insurance carrier to pay claims to D&A.

________________________________ ______________
Signature Date

Authorization for Release of Requested Records

On occasions insurance carriers do request specific medical records to justify their payment claims; I authorize D&A to release to their insurance carriers specific medical records (only if they should be requested by my insurance carriers to justify their payment on specific claims). I understand that if I should choose not to authorize D&A to release such records, I may be financially responsible for those claims.

________________________________ ______________
Signature Date

Health History

Name: ______________ Age: ________ Occupation: ______________ Marital Status: _______

What is the main purpose of your visit today?

____

____

____

Past Health: Have you ever been treated for any of the following?

Sugar Diabetes: No Yes If yes, for how long?____________________ Insulin?__________

Heart Attack: No Yes If yes, when? _________________________ Where?__________

Other heart problem: No Yes If yes, please provide details: ___________________________

____

Cancer: No Yes If yes, please provide details: ______________________________________

____

High blood pressure: No Yes If yes, for how long? _____ Medication: ____________________

Other medical problems: No Yes If yes, please provide details: ___________________________

____

Please list any medicines and vitamins you are currently taking, including herbal or over the counter medications.

_____________________________ __________________________ _____________________________

_____________________________ __________________________ _____________________________

_____________________________ __________________________ _____________________________

Please list any allergies, including food and medication allergies and what kind of reaction do you have, e.g. rash, swelling, nausea?

____

Personal Habits

Smoke cigarettes? ________ if yes, for how many years? _____ Average # of packs per day? ____

Drink coffee? __________________ if yes, how many cups per day? ______________

Drink alcohol? ___________ if yes, what do you prefer to drink? ______________________________

Eat 2-3 dairy products daily?__________________ Eat fish?___________

How many times per week do you eat out?____

Eat fruits and vegetables daily?__________ If yes, how many per day?_____________

Other diet habits:____

____

____

Family History

Please record information about your family below

	Current Age	Current Health Problems	OR	Age at Death	Cause of Death
Father	______	______		______	______
Mother	______	______		______	______

Please note problems which run in your family (for example: cancer, cholesterol):

____

____

Systems Review

Are you currently having any problems with?

	No	Yes			No	Yes
Appetite or weight?				Swallowing or digestion		
Excessive thirst or excessive urination?				Abdominal pains?		
Your eyes or your vision?				Bowel movements?		

When were your last blood sugar and cholesterol screening done and the results? Provide a copy if possible.

____

If you have any other concerns, please explain below.

____

____

Thank you for completing this information form. Please sign and date below:

______________________________ ______________________

Signature Date