

Patient Intake Form 2026

Print clearly. Complete all information.

Patient Information

LAST NAME		FIRST NAME		MIDDLE INITIAL
EMAIL ADDRESS				
SOCIAL SECURITY # (IF YOU HAVE ONE)			DATE OF BIRTH	
STREET ADDRESS			CITY, STATE	
ZIP CODE	PHONE (HOME)		PHONE (CELL)	
SEX (AT BIRTH)	☐ MALE ☐ FEMALE	PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ ARABIC ☐ OTHER _____		

Title X Intake Questions

Tell us if any of the following are true (you can choose more than one answer):

- ☐ I am here to get Nexplanon put in (or get my Nexplanon taken out).
- ☐ I am here to get an IUD put in (or get my IUD taken out).
- ☐ I am here for a well woman exam (including Pap smear and breast exam).
- ☐ I am here for other sexual health or reproductive health care.

Look for the number of persons in your family/household in the first column. Check the box in the income column that best describes your situation.

Family Size	Less Than or Equal to	Less Than or Equal to	Less Than or Equal to	Less Than or Equal to	Less Than or Equal to	Equal to or Over
1	☐ \$15,960	☐ \$19,950	☐ \$23,940	☐ \$27,930	☐ \$31,920	☐ \$39,921
2	☐ \$21,640	☐ \$27,050	☐ \$32,460	☐ \$37,870	☐ \$43,280	☐ \$43,281
3	☐ \$27,320	☐ \$34,150	☐ \$40,980	☐ \$47,810	☐ \$54,640	☐ \$54,641
4	☐ \$33,000	☐ \$41,250	☐ \$49,500	☐ \$57,750	☐ \$66,000	☐ \$66,001
5	☐ \$38,680	☐ \$48,350	☐ \$58,020	☐ \$67,690	☐ \$77,360	☐ \$77,361
6	☐ \$44,360	☐ \$55,450	☐ \$66,540	☐ \$77,630	☐ \$88,720	☐ \$88,721
7	☐ \$50,040	☐ \$62,550	☐ \$75,060	☐ \$87,570	☐ \$100,080	☐ \$100,081
8	☐ \$55,720	☐ \$69,650	☐ \$83,580	☐ \$97,510	☐ \$111,440	☐ \$11,441

Emergency Contact Information

LAST NAME		FIRST NAME	
RELATIONSHIP	STREET ADDRESS		
CITY, STATE	ZIP CODE	PHONE (CELL)	
PHONE (HOME)	PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ ARABIC OTHER _____		

Patient Intake Form 2026 (Continued)

PATIENT NAME _____ DATE OF BIRTH _____

If you don't have insurance, you can ask us for an estimate of your costs before you get care. Our staff will work with their manager to get you this estimate.

Insurance Information/Policy Holder Information

Primary Insurance Information

WHO IS THE POLICYHOLDER? ☐ Parent/Guardian ☐ Spouse ☐ Self ☐ Other _____	
INSURANCE COMPANY NAME	
INSURANCE COMPANY STREET ADDRESS	INSURANCE COMPANY CITY, STATE
INSURANCE COMPANY ZIP CODE	

Primary Insurance Policy Holder Information

POLICY HOLDER LAST NAME		POLICY HOLDER FIRST NAME	
POLICY HOLDER MIDDLE INITIAL	SUFFIX ☐ Jr. ☐ Sr. ☐ Other _____	DATE OF BIRTH	
POLICY HOLDER PHONE NUMBER		POLICY HOLDER STREET ADDRESS	
POLICY HOLDER CITY, STATE		POLICY HOLDER ZIP CODE	
POLICY ID #		GROUP/PLAN #	

Secondary Insurance Policy Holder Information

POLICY HOLDER LAST NAME		POLICY HOLDER FIRST NAME	
POLICY HOLDER MIDDLE INITIAL	SUFFIX ☐ Jr. ☐ Sr. ☐ Other _____	DATE OF BIRTH	
POLICY HOLDER PHONE NUMBER		POLICY HOLDER STREET ADDRESS	
POLICY HOLDER CITY, STATE		POLICY HOLDER ZIP CODE	
POLICY ID #		GROUP/PLAN #	

Tell us if you are worried about getting a bill for reproductive health services. We can avoid sending a bill to your address. We can also make a plan about billing your insurance. We can take these steps to protect your privacy or safety. Talk to us right away if you are worried about this.

FOR OFFICE USE ONLY	☐	DOCUMENTS REVIEWED	☐	PAY STUB	☐	TAX STATEMENT	☐	W2	☐	LETTER OF SUPPORT	☐	_____
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Patient Intake Form 2026 (Continued)

PATIENT NAME _____ DATE OF BIRTH _____

Patient Background

Race	Ethnicity	Presenting Gender (patients 18 and older only)	Sexual Orientation
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Two or More ☐ White (Caucasian) ☐ Unreported/Refused to Report	☐ Hispanic or Latino ☐ Not Hispanic or Latino Place of Birth ☐ United States ☐ Other (Please specify) _____ _____	☐ Female ☐ Male ☐ Other ☐ Decline to Answer	☐ Bisexual ☐ Lesbian, Gay ☐ Something Else ☐ Straight (Not Lesbian or Gay) ☐ Don't Know ☐ Decline to Answer

Housing Status

Are You Homeless? ☐ Yes ☐ No	Are You a Veteran? ☐ Yes ☐ No
If Yes: ☐ Shelter ☐ Street ☐ Doubling Up ☐ Transitional Housing	

Programs

Do You Currently Get Food Stamps? ☐ Yes ☐ No	Do You Currently Get WIC? ☐ Yes ☐ No	Do You Need Help Paying for Your Medicine? ☐ Yes ☐ No
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Neighborhood Health Food Pharmacy

Do You Want a Food Box Today? ☐ Yes ☐ No
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Health Literacy

Please check your responses to the questions below:

How Often Do You Have Someone Help You Read Medical Materials?	☐ Always ☐ Often ☐ Sometimes ☐ Occasionally ☐ Never
How Often Do You Have a Problem Understanding What is Told to You About Your Medical Condition?	☐ Always ☐ Often ☐ Sometimes ☐ Occasionally ☐ Never

How Did You Hear About Us?

☐ Friend/Family	☐ Our Staff	☐ Google	☐ Facebook	☐ Twitter
☐ Our Website	☐ Advertisement (Postcard, Newspaper, Etc.)	☐ I saw the Clinic	☐ Community Event	☐ Other _____

Patient Intake Form 2026 (Continued)

PATIENT NAME _____ DATE OF BIRTH _____

About You

Tell us about your background. This helps us provide the best possible care.

We will protect your privacy. We treat your information as confidential.

Allergies

Have You Ever Had an Allergic Reaction?	☐	Yes	☐	No	Medication Allergies
Food Allergies					Other Allergies (Latex, Bee Stings, Etc.)

Pharmacy Information

Pharmacy Name	Phone Number
Address/Location	

Dental

Are You Currently Having Problems with Dental Pain?	☐	Yes	☐	No	Do Your Gums Ever Bleed?	☐	Yes	☐	No
Have You Ever Taken Antibiotic Premedication Treatment?					☐	Yes	☐	No	

Family History ☐ Birth Family History Unknown

Does your family have any of the following?	Mother	Father	Siblings	Grandparents
Alcohol	☐	☐	☐	☐
Cancer (Please list type)	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Drug Dependency	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Sudden Cardiac Arrest (Under Age 50)	☐	☐	☐	☐
Other (Please Explain)	☐	☐	☐	☐
Deceased	☐	☐	☐	☐

Patient Intake Form 2026 (Continued)

PATIENT NAME _____

DATE OF BIRTH _____

Your Medical History (Please check any of the following YOU have ever had or are currently experiencing.)

- | | |
|---|---|
| ☐ ADHD | ☐ High Blood Pressure |
| ☐ Adrenal Disorders | ☐ High Cholesterol |
| ☐ Alcohol Abuse | ☐ HIV Infection |
| ☐ Anemia | ☐ Hives |
| ☐ Anorexia (Eating Disorder) | ☐ HPV |
| ☐ Anxiety Disorder | ☐ Kidney Stones |
| ☐ Arthritis | ☐ Lupus |
| ☐ Asthma | ☐ Malaria |
| ☐ Bipolar Disorder | ☐ Migraines/Severe Headaches |
| ☐ Bleeding Disorders | ☐ Multiple Sclerosis |
| ☐ Blood Clots/Clotting Disorders | ☐ Mumps |
| ☐ Bulimia (Eating Disorder) | ☐ Muscular Dystrophy |
| ☐ Cancer | ☐ Nasal Allergies/Hay Fever |
| ☐ Celiac Disease | ☐ Other Bone or Joint Problems
_____ |
| ☐ Chickenpox/Varicella | ☐ Other Liver, Stomach, or Bowel Diseases
_____ |
| ☐ Chlamydia | ☐ Other Neurological Problems
_____ |
| ☐ Chronic kidney or bladder disease | ☐ Other STD
_____ |
| ☐ Chronic sinus infections | ☐ Incontinence |
| ☐ Concussions | ☐ Infectious Mononucleosis |
| ☐ Convulsions/Seizures | ☐ Irritable Bowel Syndrome |
| ☐ COPD | ☐ Pneumonia |
| ☐ Depression | ☐ Polycystic Ovarian Syndrome (PCOS) |
| ☐ Diabetes | ☐ Psoriasis |
| ☐ Eczema | ☐ Radiation Therapy |
| ☐ Eye Disorders (Other Than Glasses or Contacts) | ☐ Schizophrenia |
| ☐ Fractures/Broken Bones | ☐ Stomach/Duodenal Ulcers |
| ☐ Genital Herpes | ☐ Stroke/TIA |
| ☐ Gonorrhea | ☐ Syphilis |
| ☐ Hearing Loss | ☐ Thyroid Disorder |
| ☐ Heart Disease/Heart Attack | ☐ Typhoid Fever |
| ☐ Heart Murmur | ☐ Ulcerative Colitis/Crohn's |
| ☐ Hepatitis Type _____ | |

OB/GYN HISTORY

Last Menstrual Period Date _____

Date of Last Pap Smear _____

History of Abnormal Pap Smears?

☐ Yes ☐ No

Date of Last Breast Exam _____

History of Abnormal Breast Exam?

☐ Yes ☐ No

Number of Total Pregnancies _____

Number of Children Delivered _____

Are You Currently Pregnant or Breastfeeding?

☐ Yes ☐ No

ACTIVITY LEVEL

Would you say your activity level is:

☐ LITTLE EXERCISE: Seated most of the day; desk job; little activity. For example: walking for 10-15 minutes 1-2 times a week.

☐ SOME EXERCISE: Activity that raises your heart rate and makes you sweat. For example: Walking briskly 30 minutes a day 5 days a week.

☐ A LOT OF EXERCISE: Activity that raises your heart rate and makes you breathe hard and fast. For example, jogging or running for 1 hour and 15 minutes every week.

SUBSTANCE USE

☐ Do You Drink Alcohol?

☐ Do You Smoke?

☐ Do You Take Recreational Drugs?

☐ Do You Vape?

Patient Intake Form 2026 (Continued)

PATIENT NAME _____

DATE OF BIRTH _____

Your Medical History

Please check any of the following YOU have ever had or are currently experiencing.

Surgical History

☐	Appendectomy		
☐	Adenoidectomy		
☐	Colon Surgery		
☐	Ear Tubes		
☐	Gallbladder Removal		
☐	Hip Surgery	☐ Left ☐ Right	
☐	Knee Surgery	☐ Left ☐ Right	
☐	Hysterectomy		
☐	Organ Transplant		

☐	Ovarian Cyst Removal
☐	Prostate Surgery
☐	Splenectomy
☐	Tonsillectomy
☐	Weight Loss Surgery
☐	Other Prior Surgeries
☐	_____
☐	_____

Other History

☐

Previous Hospitalizations/ER Visits

Please list all current medications you take.
Include prescriptions, birth control, acne, over-the-counter medications, vitamins, etc.

Your provider may order some lab tests to learn more about your health. The tests also help us find conditions such as diabetes, HIV, and hepatitis. Please tell us if you want to opt out of any test. Talk to our front desk staff to sign up for the patient portal so you can check your results.

Patient Consent Form

PATIENT NAME _____

DATE OF BIRTH _____

	Summary	Full Details
Initial _____ Here _____	I want to get the care that Neighborhood Health (NH) recommends for me. * It is okay for Neighborhood Health to treat me. * *or a minor child, if a minor child is the patient and I am the parent or legal guardian and I can authorize treatment.	I consent to the evaluation and treatment as may be deemed necessary or advisable in the judgment of a Neighborhood Health physician or another clinical provider. This may include, but is not limited to an interview, physical examination, laboratory studies, or other services rendered the patient under the general and special instructions of the provider. I know I can get family planning services here, or I can choose not to get these services. My choice about family planning does not affect whether I can get other services here. I also consent for a Neighborhood Health physician or other clinical provider to treat, diagnose, operate on, or prescribe for any physical ailment, physical injury, or deformity; prescribe, dispense, deliver, or administer any drug or medication; and render psychological or counseling services. If I am providing this consent for a minor child, either (a) I am the parent or legal guardian of the child and have the authority to provide this consent for this child; or (b) I have otherwise been granted authority to make decisions regarding this child's health care under state law (or I am a minor child who can consent to get care under state law).
Initial _____ Here _____	I agree the insurance company, Medicare, TennCare, or other programs can pay my bill. I allow Neighborhood Health to keep these payments. Also, I agree to let Neighborhood Health be my primary care provider, and I give Neighborhood Health permission to tell my insurance company about this.	In consideration of services rendered, I hereby transfer and assign to Neighborhood Health all rights, title, and interest in any payment due to me (or my child) for services described herein as provided in the above-mentioned policy or policies of insurance. Neighborhood Health may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient) for all or part of the clinic's charge, including but not limited to medical and dental service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer. I hereby agree that all Medicaid/Medicare payments pertaining to my treatment (or that of my child) shall be assigned to Neighborhood Health. Tell us if you are worried about getting a bill for reproductive health services. I authorize Neighborhood Health to submit a primary care provider (PCP) change request to my insurance company on my behalf (or that of my child). I understand that I can contact my insurance provider to request a change in PCP at any time.
Initial _____ Here _____	I agree to pay the fees I owe that are not covered by insurance, Medicare, TennCare, or other programs.	I agree, in consideration of the services to be rendered to me (or my child), I am obligated to pay applicable fees based on my household income and family size. I understand Neighborhood Health may file insurance claims as a courtesy; however, if a claim is denied for any reason, I am responsible for payment. I also understand I must pay any co-pay, deductible, co-insurance, or any other balance not paid for by my insurance or third-party payer (or that of my child) within a reasonable period of time, not to exceed ninety (90) days. Tell us if you are worried about getting a bill for reproductive health services.
Initial _____ Here _____	Neighborhood Health can contact me by phone, email, and text.	I give my permission for Neighborhood Health to contact me by phone, email, and text regarding appointments, lab results, billing, and announcements. I know I can opt out by telling Neighborhood Health I do not want to get messages in a particular form or way.
Initial _____ Here _____	Neighborhood Health may obtain a list of my medications.	I give Neighborhood Health permission to get a list of all my medications (including my past medications) from my pharmacies, other health care providers, and my insurers. I give my permission for these entities to share my information with Neighborhood Health. This will become part of my health record here.
Initial _____ Here _____	Neighborhood Health offered me a notice about privacy. Neighborhood Health also offered me notice about my rights as a patient.	I have been offered (a) a copy of the Neighborhood Health HIPAA Notice of Privacy Practices; and (b) Neighborhood Health Patient Rights and Responsibilities. I also know Neighborhood Health will email or mail me a copy if I ask.
Initial _____ Here _____	I know Neighborhood Health will keep a copy of this.	I authorize Neighborhood Health to use a copy of these authorizations and assignments. Neighborhood Health will file any hard copy original. Your authorization remains valid unless and until you revoke it in writing.
Initial _____ Here _____	I know everyone is welcome at Neighborhood Health.	If I have been discriminated against based on race, color, or national origin, I know I can file a "Title VI" complaint with Neighborhood Health by calling 615-227-3000 x 1007. I can also file a complaint with the regional or central office of the Department of Mental Health and Substance Abuse Services or the Office of Civil Rights, 101 Marietta Tower, Suite 2706, Atlanta, GA
Initial _____ Here _____	I agree to get the lab tests Neighborhood Health recommends.	Your provider may order some lab tests to learn more about your health. The tests also help us find conditions such as diabetes, HIV, and hepatitis. Please tell us if you want to opt out of any test. Talk to our front desk staff to sign up for the patient portal so you

Patient Consent Form

Here		can check your results.
Initial _____ Here	I know that Neighborhood Health may use AI scribing to help document my visit.	We may use scribing tools to help document what occurred during your visit. This helps us focus on you rather than a need to type throughout your visit. The scribing tools may use artificial intelligence (AI) technology. However, your provider will review all documentation, though, before it becomes part of your chart. Tell your provider if you do not want us to use these scribing tools today.
Initial _____ Here	I agree Neighborhood Health can share my information with WeGo if I get a WeGo Journey Pass.	If I live in Nashville, Neighborhood Health may offer me a WeGo Journey Pass. This would allow me to ride WeGo buses for free for 3 years. If I accept a Journey Pass, I am saying I agree Neighborhood Health has my permission to send my full name, date of birth, phone number, and email to WeGo. WeGo will use this to keep track of my Journey Pass and to contact me to renew it. WeGo requires this information for all Journey Passes. If I do not want Neighborhood Health to send my information to WeGo, I will not accept the WeGo Journey Pass.

By signing below, I am saying: I am the adult patient on this form, or I am the parent (or legal guardian) of the child on this form unless I check the box below.

☐ I am a minor child who is emancipated, pregnant, or a parent of a child for whom I have custody, **and** I know I must **also** complete the "Exception Form to Accept Consent of a Minor Child."

I know Neighborhood Health will use the information on this form when providing care to me and my family. All of the information I put on this form is true and accurate.

SIGNATURE: X _____ **DATE:** _____