Acct #________________________ Diagnosis __________________________________

Appointment Date ______________ Referred by _________________________________

Therapist _____________________

**NORTHSHORE CLINIC, LLC**
**805 NORTH 6TH STREET**
**SHEBOYGAN, WI 53081**
**920-457-8866**

## INTAKE FORM/INSURANCE INFORMATION

Client Information:

_____________________________________________________________________________
Last Name* First Middle *Maiden Name, if applicable

_____________________________________________________________________________
Date of Birth Sex Marital Status

_____________________________________________________________________________
Address City State Zip Code

_____________________________________________________________________________
Employer Address of Employer City State

Your therapist or the billing staff may need to contact you regarding scheduling, billing questions, etc. Please review the following questions and respond accordingly:

May we call you at home? **Y** **N** _____ (Please initial) Phone# ___________________________

May we call you on your cell phone? **Y** **N** ______ (Please initial) Phone# ____________________

May we call you at work and leave a message? **Y** **N** ______ (Please initial) Phone# ______________

Are there any restrictions to leaving a message at any of the above? _______________________________

May we correspond with you by email? **Y** **N** ______ (Please initial)

Email address ________________________________________

**Please turn this page over for insurance information**

# INSURANCE INFORMATION

**PRIMARY INSURANCE**:

______________________________________________________________________

Subscriber Name (Last, First, Middle) Birthdate Sex

______________________________________________________________________

Subscriber Address City State Zip Code

______________________________________________________________________

Subscriber Home Phone Subscriber Work Phone Employer

______________________________________________________________________

Insurance Company Name Phone Number

______________________________________________________________________

Insurance Company Address City State Zip Code

______________________________________________________________________

Subscriber ID Number Group Number

Relationship to Patient: _____________________

**SECONDARY INSURANCE**

______________________________________________________________________

Subscriber Name (Last, First, Middle) Birthdate Sex

______________________________________________________________________

Subscriber Address City State Zip Code

______________________________________________________________________

Subscriber Home Phone Subscriber Work Phone Employer

______________________________________________________________________

Insurance Company Name Phone Number

______________________________________________________________________

Insurance Company Address City State Zip Code

______________________________________________________________________

Subscriber ID Number Group Number

Relationship to Patient: _____________________

**It is your responsibility to inform our office if your insurance changes or you acquire any type of Medicaid coverage at a later time. If you do not provide us with the updated/accurate information in a timely manner you may be responsible for the balance of your bill.**
**______________ (Please initial)**

NORTHSHORE CLINIC, LLC
805 North 6th Street
Sheboygan WI 53081
(920) 457-8866

## CONSENT TO USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION

**Client Name** ___________________ **Account Number** _______________

**Date of Admission** ______________

By signing this form, you are agreeing to let us use your personal health information (PHI) here and to send it to those outlined in our Notice of Privacy Practices. You are acknowledging that you have read Northshore Clinic's Notice of Privacy Practices (summarized or full version) and understand how your health information can be used or disclosed (shared), as described therein. You are agreeing that you have been offered a copy of our Notice of Privacy Practices (NPP) and have been encouraged to discuss any concerns you may have. You have also been given a copy of your rights as a patient of Northshore Clinic, LLC, including your right to restrict, review or stop this consent.

**If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.** In addition, if you choose to revoke this consent at any time, treatment will terminate.

If in the future, we change our Notice of Privacy Practices, we will post and date any changes made and provide copies of our new NPP for your review.

_____________________________________ _____________
Signature of client or legal representative Date

_____________________________________
Description of legal representative's authority

## TO BE COMPLETED BY ADMITTING CLINICIAN

Was the client asked if they had any questions or concerns about Northshore's Notice of Privacy Practices?

☐ YES

_______________________________________ _____________________

Signature of Staff Member Date

## TO BE COMPLETED BY OFFICE STAFF

Briefly describe the efforts made to obtain the client's signature and explain why the client was unable or unwilling to sign this form:___________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

________________________________ _____________________

Signature of Staff Member Date

## MEDICAL HISTORY

NAME: __________________________ AGE: _____ DATE OF BIRTH: __________ DATE: __________

Have you ever had or been treated for the following conditions:

| | | | |
|---|---|---|---|
| ❒ Allergies | ❒ Blood Disease | ❒ Blood Pressure | ❒ Back Trouble |
| ❒ Hay Fever | ❒ Cancer | ❒ Heart Disease | ❒ Arthritis |
| ❒ Asthma | ❒ Diabetes | ❒ Kidney Disease | ❒ Chronic Pain |
| ❒ Emphysema | ❒ Low Blood Sugar | ❒ Bladder Problems | ❒ Headaches |
| ❒ Skin Problems | ❒ Thyroid Problems | ❒ Prostate Disease | ❒ Injury/Fracture |
| ❒ Constipation | ❒ Liver Disease | ❒ Menstrual Problem | ❒ Epilepsy/Seizure |
| ❒ Stomach Problems | ❒ Hearing Problems | ❒ Abortion/Miscarry | ❒ Eating Disorder |
| ❒ Irritable Bowel | ❒ Vision Problems | ❒ Sexual Problems | ❒ Drinking Problem |
| ❒ Weight Problems | ❒ Dental Problems | ❒ Sleep Problems | ❒ Drug Abuse |

Please list any hospitalizations (dates and reasons):_________________________________________________

_____________________________________________________________________________

Please list all prior mental health services received:

With Whom: Year: How Long: For What:

Have you ever been: physically abused ❒ or sexually molested ❒ ?

Are you currently under the care of a doctor for any physical or emotional condition?
If so, please list doctor's name, reason for treatment, date last seen: _____________________________________

_____________________________________________________________________________

Current medications you are taking: _______________________________________________________

_____________________________________________________________________________

Current Health Concerns: Please check any area where you think you may have a problem:

| | | |
|---|---|---|
| ❒ Hearing/Vision | ❒ Anxiety/Nervousness | ❒ Interpersonal Relationships |
| ❒ Speech | ❒ Depression | ❒ School Problems |
| ❒ Dental Health | ❒ Anger or Temper | ❒ Work/Job/Career Problems |
| ❒ Breathing | ❒ Frequent Mood Changes | ❒ Marital Problems |
| ❒ Circulation | ❒ Guilt | ❒ Parenting Skills |
| ❒ Digestion | ❒ Self-Concept | ❒ Sexuality |
| ❒ Bowel Function | ❒ Tiredness/Fatigue | ❒ Problems with Relatives |
| ❒ Urinary Function | ❒ Sleep Disturbances | ❒ Legal |
| ❒ Joint/Muscle Function | ❒ Suicide Ideas | ❒ Exercise, Hobbies |
| ❒ Skin Condition | ❒ Indecision | ❒ Drinking Problems |
| ❒ Pain | ❒ Memory/Concentration | ❒ Drug Problems |
| ❒ Menstrual Cycle | ❒ Eating/Appetite | ❒ Behavior Problems |
| ❒ Menopause | ❒ Weight Loss/Gain | ❒ Other:________________ |
| ❒ Smoking | ❒ Phobias | |

Name of your physician: _________________________________________________________________

Client Signature: ___________________________________________________ Date: ________________