INFINITY HEALTH CONSULTANTS, LLC

As our patient, you will soon experience what everyone has been talking about… modern medicine. Infinity Health Consultants is a medical practice composed of highly trained and compassionate providers that specialize in treating patients virtually and in their home setting.

Please review, sign and return the enclosed documents. Once Infinity Health Consultants receives your information, we will contact you and schedule your appointment.

Our providers aim to provide personal service that treats every patient with respect and dignity.

Virtual Health (Telehealth/Telemedicine)

Method by which the Nurse Practitioner communicate with patients without physically seeing them in the office (skype, FaceTime), secured and HIPPA compliant. This type of healthcare is beneficial for those too busy for an office visit. It helps those that are unable to leave work, college students, lack of mobility, have limited access to transportation, or live in remote areas.

If you have any questions or concerns about our service, please call our office. We want to do everything we can to help you!

Thank you for the opportunity to care for you.

PLEASE RETURN THE FOLLOWING DOCUMENTS (INTAKE FORMS)

- Patient Questionnaire
- Signed Consent for Treatment

Things you should know…

SCHEDULING (House Calls visit)

- Once your intake forms are received and reviewed, your visit will be scheduled within 24 hours

SCHEDULING (Virtual Visit)

- Once your intake forms are received and reviewed, you will be able to sign into our virtual office. You will be able to make your secured payment prior to seeing your provider.

We know that you want immediate answers to your illness, but there are some conditions that **we can't treat** and will recommend seeking emergency attention at your nearest Emergency Room. These conditions include:

Abdominal pain

Chest Pain

Difficulty Breathing

Work Related Injuries

Traumatic Injuries

Eye Injuries

Animal Bites

Patient Questionnaire

Patient Name: _____ Date: ____/____/____

Last: _____ First: _____ MI: _____

Patient Gender: Female: ☐ Male: ☐

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____

Email Address _____

Emergency contact name: _____

Relationship: _____ Phone Number: _____

Patient Health Information

Age: _____ Height: _____ Weight: _____ Date of Birth: _____

Current Medications

Please list all medications that you are taking, including vitamins and over the counter medications:

	Name	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

What is your complaint for today?_____

_____

Medical History

Check all that apply:

Alcoholism		Diabetes		High Blood Pressure	
Arthritis		Eczema/Skin Issues		HIV/AIDS	
Anxiety/Depression		Emphysema/Asthma		Intestinal Issues	
Autoimmune Disease		Eye Issues		Muscle Problems	
Bladder/Kidney		Headaches		Respiratory Issues	
Cancer		Heart Disease		Scarlet Fever	
Stroke		Swallowing Issues		Other:	

Allergies: Yes ☐ No ☐

If yes, please list:

Medications				
Latex				
Food				

Surgeries/hospitalizations

Please list any prior surgeries or hospitalizations:

Surgery	Date

Name of Pharmacy: _____ Phone: _____

Do you currently have a Primary Care Physician? Yes ☐ No ☐

If yes, please provide your Primary Care Physician's information:

Name: _____ Phone: _____ Fax: _____

Thank you for your time and attention to this material. The information you provide will help us to provide care for you.

Signature: _____ Today's Date: ____/____/____

Consent to Treat

Patient Name: _____Date: _____

_____ I hereby authorize and consent to the performance of physical examination and treatment by a physician, from Infinity Health Consultants, LLC. If, I choose to have a family member or another individual present during my physical examinations I will indicate by placing my initials here_____. I understand that this consent is given in advance. This may include blood draws, urinalysis, ultrasounds, x-rays, administration of vaccines and removal of sutures. I hereby grant permission to Infinity Health Consultants to view my prescription history from an external source.

NOTICE OF PRVIACY PRACTICES ACKNOWLEDEMENT

_____ I acknowledged that I have been offered a copy of Infinity Health Consultants (IHC). I understand that IHC provides information about how protected health information about me may be used and disclosed in providing care to me and receiving payment for that care. I understand that the terms of the notice may change as allowed by law.

_____ _____

Signature of Patient Date