Berachah Nursing PLLC
Professional care with blessing and hope

Virtual / Telehealth — Texas · (903) 724-6624 · jumoke@berachahnursing.care · Sun–Fri, 9 AM – 6 PM

NEW PATIENT INTAKE FORM

Please print and complete this form before your first visit. If you need help filling it in, call us at (903) 724-6624.

1. Patient Information

Last name _____ **First name** _____ **Middle initial** _____

Date of birth _____ **Gender** ☐Female ☐Male ☐Other **Phone (cell)** _____

Street address _____ **City** _____ **State** _____ **ZIP** _____

Email _____ **Preferred contact** ☐Phone ☐Email ☐Text message

Emergency contact name _____ **Relationship** _____ **Phone** _____

2. Insurance Information

Primary insurance plan _____ **Member ID** _____ **Group no.** _____

Subscriber name (if not the patient) _____ **Subscriber date of birth** _____

Secondary insurance (if any) _____ **Member ID** _____

Please have your insurance card available at the time of your visit so we can verify your coverage.

3. Reason for Your Visit

What would you like help with?

_____

_____

_____

4. Conditions

Please check any conditions you have now, or have been treated for:

☐ Hypertension (high blood pressure) ☐ Diabetes ☐ Heart Failure ☐ COPD ☐ Obesity ☐ Asthma

☐ Allergies ☐ Sinus problems ☐ Headaches ☐ Rash / skin problems ☐ Urinary tract infections (UTI)

Other _____

5. Current Medications

Medication name	Dose	How often

6. Allergies

☐ **No known allergies** **List any medication or other allergies, and how you react** _____

_____

7. Medical History

Past illnesses, surgeries, or hospital stays:

_____

_____

Family medical history (parents, brothers and sisters):

_____

_____

8. Pharmacy

Pharmacy name _____ **City** _____ **Phone** _____

9. Consent and Signature

☐ I understand that my care at Berachah Nursing Care PLLC is provided by telehealth (video or phone visits), and I consent to receive care in this way.

☐ I confirm that the information on this form is true and complete to the best of my knowledge, and I will tell the practice about any changes.

Signature _____ **Print name** _____ **Date** _____

If the patient is a minor or unable to sign, the parent, guardian, or legal representative should sign above and note their relationship to the patient.