First name: ______________________________ Last name: ____

Address: ________________________________ City: ________________________State: _______ Zip code: __________

Best Phone: _____________________________ Email: ____

Date of birth: ____________ Height: _________ Profession: ____

How did you find us? ☐ Google ☐ Facebook ☐ Instagram ☐ OBH Client ______________ ☐ Other: ______________

Do you exercise: ☐ Daily ☐ Weekly ☐ Never ☐ Other : _______________________________

Please list any physicians you currently see and their specialty:
Dr. ____ Specialty: _______________________
Patient Since: ____ Last Visit: _______________________
Dr. ____ Specialty: _______________________
Patient Since: ____ Last Visit: _______________________

Please check ☑ if you presently have or have had any of the following conditions or circumstances:

Do you have a surgery within the next month? ☐ Yes ☐ No
Do you have a vacation scheduled within the next month? ☐ Yes ☐ No

☐ Severe Liver Disease
☐ Severe Kidney Disease
☐ Diagnosis of Parkinson's
☐ Currently on Lithium Therapy
☐ Heart Attack within 6 Months

☐ Currently Undergoing Cancer Treatment
☐ Strict Vegan Lifestyle
☐ Currently Pregnant
☐ Alzheimer's Disease
☐ None of These Conditions Apply

☐ Arrhythmia (Abnormal Heart Rhythm)
☐ Kidney Disease
☐ Kidney Transplant
☐ Coronary Artery Disease
☐ Heart Valve Problem
☐ Epilepsy -seizure w/in 1 year
☐ Blood Clot-Taking Blood Thinner
☐ Hyperkalemia (High Potassium Level)
☐ Pulmonary Embolism- Taking Blood Thinner
☐ Currently on a Sodium-Glucose Co-Transporter inhibitor (SGLT-2)

☐ Stroke or Transient Ischemic Attack (TIA)
☐ History of Congestive Heart Failure
☐ Child Under Age 17
☐ Gastric Ulcer
☐ Heart Valve Replacement
☐ History of Heart Attack w/in 1 year
☐ Hypokalemia (Low Potassium Level)
☐ History of Cancer:
  ☐ 5 Years or Less
  ☐ More than 5 years
☐ None of These Conditions Apply

List ALL medications (prescription and OTC) and supplements you currently take, as well as any recent vaccines.

Name:________________________ Dose: ________________________

Name:________________________ Dose: ________________________

Name:________________________ Dose: ________________________

Name:________________________ Dose: ________________________

Name:________________________ Dose: ________________________

Name:________________________ Dose: ________________________

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Name:________________________ Dose: ________________________

Name:________________________ Dose: ________________________

Name:________________________ Dose: ________________________

Name:________________________ Dose: ________________________

Name:________________________ Dose: ________________________

Consent to Use or Disclose Health Information
(HIPAA Disclosure)

I authorize **Optimal BioHealth** to use and disclose the health and medical information of for the purposes of Treatment, Payment and Health Care Operations including communication via email, phone, and text message. I understand I may opt-out of individual forms of communication in writing.*

***Treatment** includes activities performed by a health care provider, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

***Health Care Operations** includes the necessary administrative and business functions of our office.

You may review Optimal BioHealth's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Optimal BioHeal has already used or disclosed the information in reliance on this Consent, I understand health care providers generally may not condition treatment on the provision of the authorization.
This consent expires one year from termination of care unless otherwise revoked.

SIGNATURE: ____ DATE: ________________

PRINT NAME: ____