Dillon Lambert, APRN
7111 So. Virginia St. Suite A-12, Reno, NV 89511
Phone: 775-984-4200 Fax: 775-971-4314
Website: thrivetobehealthy.com

WELCOME TO THRIVE INTEGRATIVE HEALTH

At THRIVE Integrative Health, we value and embrace the patient-centered approach. We attempt to find the root causes of the problem and provide individualized treatments to our patients. We strive to bridge the gap between conventional and complementary medicines to optimize your health and wellness.

We do not discriminate based on race, age, gender, sexual orientation, religious beliefs or any other factors. We believe that all patients should have access to equitable healthcare that does not differ according to personal characteristics. Be advised that we do see patients that have not had vaccines and patients that are fully vaccinated. We take great pride to ensure that our patients have a clean, safe, friendly, comfortable environment to manage their healthcare needs.

CONSENT FOR TREATMENT

I authorize the Medical and Nursing Staff at Thrive Integrative Health to perform diagnostic tests, administer medicine, and implement treatment plans for any and all medical conditions. I fully recognize and understand that the medical treatments I may receive include nutrient, herbal, integrative, alternative, preventative and/or conventional therapies.

I also understand that Thrive Integrative Health Medical Staff will NOT provide hospitalized care in cases where hospitalization is necessary.

_____ Date of Birth: _____/_____/_____
Patient Name (print)

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

THRIVE
Integrative Health

Dillon Lambert, APRN
7111 So. Virginia St. Suite A-12, Reno, NV 89511
Phone: 775-984-4200 Fax: 775-971-4314
Website: thrivetobehealthy.com

PATIENT DEMOGRAPHICS AND REGISTRATION

Today's Date: _____/_____/_____

Patient Name: _____
Last First MI

Preferred Name: _____ Date of Birth: _____/_____/_____

Gender: Male Female Transgender (M-F or F-M) Marital Status: M S D W

Responsible Party: _____ Date of Birth: _____/_____/_____

Patient SS#: _____-_____-_____ Responsible Party SS#: _____-_____-_____

Primary Address: _____
Street City State Zip

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Email Address: _____

Occupation: _____ Employer: _____

Work Phone: ( ) _____-_____ DL/ID#: _____

Primary Insurance: _____ Phone: ( ) _____-_____

Policy#: _____ Group#: _____

Secondary Insurance: _____ Phone: ( ) _____-_____

Policy#: _____ Group#: _____

Preferred Pharmacy: _____

Preferred Lab: _____ Preferred Hospital: _____

Emergency Contact: _____ Phone: ( ) _____-_____

Dillon Lambert, APRN
7111 So. Virginia St. Suite A-12, Reno, NV 89511
Phone: 775-984-4200 Fax: 775-971-4314
Website: thrivetobehealthy.com

PATIENT HEALTH INFORMATION

Name: _____DOB: _____/_____/_____Date:_____/_____/_____

Describe your current medical symptoms or concerns:_____

_____

_____

Past Medical History:

_____

_____

_____

_____

_____

Past Surgical History (what year?):

_____

_____

_____

_____

_____

Family History
(Please check boxes for all known conditions and indicate if alive or deceased)

	Mother **Alive Y or N**	Father **Alive Y or N**	Maternal Gma **Alive Y or N**	Maternal G-pa **Alive Y or N**	Paternal G-ma **Alive Y or N**	Paternal G-pa **Alive Y or N**
No concerns	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding dis.	☐	☐	☐	☐	☐	☐
CAD	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐	☐
Heart Dis.	☐	☐	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐	☐	☐
High BP	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer (type)	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

Social History:

Smoking status: ☐ Never Smoker ☐ Current Smoker (how much)_____/day
☐ Former Smoker (how much)_____/day Age started: _____ Quit: _____
Alcohol: ☐ Do not drink ☐ Occasional drink (how much)_____drinks per_____
☐ Frequently drinks (how much)_____drinks/day ☐ History of Alcoholism
Drug use: ☐ No illicit drug use ☐ Illicit drug use (please explain) _____
Heath/Safety: ☐ Eat healthy meals ☐ Regular exercise ☐ Take daily aspirin
☐ Household smoke detector ☐ Keep firearm in the home ☐ Wears seatbelt

List your current medications including nonprescription, supplements and herbs:

Medication	Strength	Frequency	Condition taken for

List any allergies to medication (including reaction):

_____

_____

Please mark any symptoms you are currently experiencing or have recently experienced:

	Fever		Lip Sores		Constipation		Blackouts
	Night Sweats		Sore Throat		Diarrhea		Numbness
	Chills		Dental Problems		Pain with Urination		Tingling
	Cold Intolerance		Hoarse Voice		Blood in Urine		Tremor
	Fatigue		Neck Pain		Urine Dribbling		Change in Mood
	Sleepiness		Neck Stiffness		Frequent Urination		Depression
	Vision Change		Neck Lumps		Sexual Dysfunction		Anxiety
	Vision Loss		Shortness of Breath		Itching		Sleep Disturbance
	Blurred Vision		Cough		Hives		Suicidal Ideation
	Eye Redness		Productive Cough		Rash		
	Eye Discharge		Coughing up Blood		New/Unusual Mole		
	Hearing loss		Wheezing		Muscle Pain		
	Ear Pain/Ache		Chest Pain		Back pain		
	Ear Drainage		Palpitations		Tender Points		
	Ear Ringing		Short Breath at Rest		Muscle Cramps		
	Nasal Congestion		Abdominal Pain		Muscle Weakness		
	Nasal Discharge		Rectal Pain		Headaches		
	Bloody Noses		Nausea		Vertigo		
	Sneezing		Vomiting		Lightheadedness		
	Snoring		Vomiting Blood		Fainting		

Dillon Lambert, APRN
7111 So. Virginia St. Suite A-12, Reno, NV 89511
Phone: 775-984-4200 Fax: 775-971-4314
Website: thrivetobehealthy.com

ASSIGNMENT OF INSURANCE BENEFITS AND FINACIAL AGREEMENT

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Thrive Integrative Health Dillon Lambert, APRN. This assignment will remain in effect until revoked by me in writing, A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by my insurance carrier.
I hereby authorize said assignee to release all information necessary to secure payment. I understand that I am responsible for the balance and remaining fees not paid by my Insurance.

I understand that if I do not pay my account in full, that my account may be assigned to a collection agency for collection. I understand that if my account is assigned to a collection agency, the collection agency will charge a commission or fee that may be as much as 50% of the amount I owe. I agree that if my account is assigned to a collection agency, the amount of the commission or fee is in addition to the amount I owe, and I agree to pay that amount. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees. I also understand that I my care will no longer by managed at Thrive Integrative Health should my account be sent to a collection agency.

I have read the above Assignment of Insurance Benefits and Financial Agreement and am accepting full financial responsibility for payment of professional services and any of my medical treatments.

_____ Date of Birth: _____/_____/_____
Patient Name (print)

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

_____
Representative of Thrive Integrative Health

Dillon Lambert, APRN
7111 So. Virginia St Suite A-12 Reno, NV 89511
Phone: 775-984-4200 Fax: 775-971-4314
Website: thrivetobehealthy.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that Thrive Integrative Health has given me a copy of its Notice of Privacy Practices.

_____ Date of Birth: _____/_____/_____
Patient Name (print)

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

_____
Guardian Signature (if patient in under 18 years old)

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I, _____,

am hereby providing written consent authorizing _____to:

_____ discuss my medical condition(s) and review all medical related correspondence
_____ discuss billing, insurance and other financial related items to my medical visits
_____ to schedule provider appointments on my behalf at Thrive Integrative Health

The authorization confirmed the above will remain in effect until I provide written notice ending this authorization.

_____ Date of Birth: _____/_____/_____
Patient Name (print)

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

_____
Guardian Signature (if patient in under 18 years old)