NEW PATIENT FORM

Please print this form single-sided and bring with you completed to your first appointment along with your insurance card (if applicable) and driver's license.

PATIENT INFORMATION

Name: ______________________ Birth date: __________
Preferred name (if different): ______________ Gender: __________
Parent/guardian name (if minor): ______________________
Address: ______________________
City: ______________ State: ________ Zip: __________
Preferred phone: ______________ ☐ Home ☐ Work ☐ Cell
Okay to leave confidential voice mail? ☐ Yes ☐ No
Alternate phone: ______________ ☐ Home ☐ Work ☐ Cell
Okay to leave confidential voice mail? ☐ Yes ☐ No
Email address: ______________
Employer: ______________
Referred by: ______________
In case of emergency, notify: ______________________
Phone: ______________ Relationship: ______________

Primary Insurance: ______________________
Your relationship to the Insured (subscriber) on the card: ☐ Self ☐ Spouse ☐ Child ☐ Other
Name of Insured (subscriber): ______________________
Birth date of Insured: ______________ Employer of Insured: ______________

Secondary Insurance (if applicable): ______________________
Your relationship to the Insured (subscriber) on the card: ☐ Self ☐ Spouse ☐ Child ☐ Other
Name of Insured (subscriber): ______________________
Birth date of Insured: ______________ Employer of Insured: ______________

WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD & DRIVER'S LICENSE.

By signing below, I declare the information provided above is true and factual.

Patient/guardian signature: ______________________ Date: ______________

Acknowledgment of Receipt of Privacy Practices (HIPPA)

I acknowledge receipt of this provider's Notice of Privacy Practices (under New Patient Forms).

Patient/guardian signature: ______________________ Date: ______________

PAYMENT POLICY / CANCELLATION POLICY

Naturopaths are not always covered by all plans of insurance companies. Call the Customer Service phone number on the back of your insurance card to check your benefits before your first visit.

IF NOT COVERED BY YOUR INSURANCE, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICES.
It is then your responsibility to submit claims to your insurance plan for reimbursement of the office fees. This office and your insurance card/company will provide you with the information necessary. Secondary insurance company billing is the patient's responsibility unless doctor is contracted with the secondary insurance company.

It is your responsibility to find out if your insurance is contracted for lab work ordered by the doctor. I understand that all lab test fees are determined by the lab, and if not covered by patient's insurance, becomes the responsibility of the patient.

IT IS YOUR RESPONSIBILITY TO KNOW THE TERMS OF YOUR COVERAGE FOR EACH VISIT INCLUDING:

- Whether naturopathic services are covered.
- If there is a deductible to meet first.
- If a referral is required from your primary care provider. If so, it is your responsibility to obtain the referral and provide our office with a referral number before your appointment.
- If you have a co-payment. If so, it is due at the time of services.
- If lab tests are covered – both the test itself and the facility used are separate practices and bill separately. It is your responsibility to give your insurance info to the labs.

It is your responsibility to be aware of your appointment date and time. We request at least 24-hour notice from you for an appointment cancellation or rescheduling. Failure to do so may incur a cancellation fee or missed appointment fee up to the cost of the scheduled visit.

YOU ARE DIRECTLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES INCURRED UNDER OUR CARE.
We accept payment by cash, check, and credit cards.
We charge $35.00 for returned checks.
Delinquent accounts may be sent to a collections service for collection.

- I understand that I am responsible for my account balance.
- I understand that certain procedures may not be covered by my insurance and I understand in such cases, if payment is denied by insurance, I am responsible for payment of such received procedures.
- I authorize release of information to all my insurance companies if requested.
- I authorize my doctor to help me obtain payment from my insurance if she is contracted.
- I authorize payment directly to my doctor from my insurance.
- I understand that I am responsible for my account balance with facilities used for any lab work.
- I permit a copy of this authorization to be used in place of the original.

I understand and agree to the above policy. I will abide by its terms.

Name (printed): ____ Date: _____________________
Patient/guardian signature: ____

Patient name: ______________________________ Birth date: ______________

Health History

This history form provides us with information to help us meet your healthcare needs. Please answer each question as thoroughly as possible and use N/A for any questions that do not apply to you. This is a confidential part of your medical record.

Please list why you are seeking care and (in order of importance) the health concerns, symptoms, or problems you are experiencing: ______________________________

____

____

____

☐ I am seeking a new Primary Care Provider (PCP)

☐ I have a PCP already and am seeking adjunctive naturopathic and/or homeopathic care

Name of Primary Care Provider: ______________________________

MEDICAL HISTORY

Last physical exam: ______________Last bloodwork: ______________

Other screenings such as colonoscopy, bone density/DEXA, mammogram (list date of screening and if abnormal): ______________________________

____

____

Do you visit the dentist at least once per year? ☐ Yes ☐ No Are immunizations up to date? ☐ Yes ☐ No

Please select if you have ever had any of the following conditions:

☐ ADHD
☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Autoimmune disease
☐ Bipolar disorder
☐ Bleeding disorder
☐ Blood transfusion
☐ Cancer
☐ Celiac disease
☐ Chickenpox
☐ Congestive heart failure
☐ Clotting disorder
☐ COPD
☐ Crohn's disease
☐ Depression
☐ Diabetes
☐ Eating disorder
☐ Eczema
☐ Endometriosis
☐ Fibroids
☐ Fibromyalgia
☐ Gallstones
☐ GERD
☐ Glaucoma
☐ Gout
☐ Heart disease
☐ Heart murmur
☐ Hemorrhoids
☐ Hepatitis
☐ Hernia
☐ High blood pressure
☐ HIV/AIDS
☐ Hives
☐ Irritable bowel syndrome
☐ Kidney disease
☐ Low blood pressure
☐ Measles
☐ Meningitis
☐ Migraine headaches
☐ Mitral valve prolapse
☐ Mononucleosis
☐ Multiple sclerosis
☐ Mumps
☐ Osteoporosis
☐ Parkinson's
☐ PCOS
☐ Pneumonia
☐ Psoriasis
☐ Scarlet fever
☐ Seizures
☐ Sleep apnea
☐ Stroke
☐ Substance abuse
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcer
☐ Ulcerative colitis
☐ Urinary tract infection
☐ Whooping cough

Other: ______________

____

____

____

Patient name: ______________________________ Birth date: ____________

Please list all serious illnesses, injuries, operations, and hospitalizations you have experienced (include year occurred): ______________________________

____

____

GYNECOLOGICAL HISTORY (Women only)

Age period began: ____________

Date of last pelvic exam: ____________

Testing done: ☐ Pap ☐ HPV ☐ STD

Any abnormal results? ☐ Yes ☐ No

Date of last period: ____________

Length of period: ____________

Days between periods: ____________

Type of birth control used: ____________

Number of pregnancies: ____________

Number of full term births: ____________

Number of preterm births: ____________

FAMILY HISTORY

Has any blood relative had any of the following? Please indicate M (Mother), F (Father), S (Sibling), MGM (Maternal Grandmother), MGF (Maternal Grandfather), PGM (Paternal Grandmother), or PGF (Paternal Grandfather)

	M	F	S	MGM	MGF	PGM	PGF
Allergies							
Alzheimer’s disease							
Anxiety							
Asthma							
Autoimmune disease							
Cancer (specify type)							
Celiac disease							
Depression							
Diabetes							
Eczema							
Heart disease							
High blood pressure							
High cholesterol							
Kidney disease							
Migraine headaches							
Obesity							
Osteoporosis							
Stroke							
Substance abuse							
Thyroid disease							
Tuberculosis							
Other:							

If any relatives above are deceased, please list the relative, their age at death, and cause: ____________

____

Patient name: ____ Birth date: ______________

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner
Do you have children? ☐ Yes ☐ No (If yes, what are their ages?) ____________________
Occupation: ____________________Previous occupations: ____________________
Hobbies: ____
Exercise/recreation (type and how often): ____________________
Past or current tobacco use: (type & amount per day): ______________Date quit: ________
Do you consume caffeine? ☐ Yes ☐ No (If yes, specify type & amount per day): ______________
Do you consume alcohol? ☐ Yes ☐ No (If yes, specify type & amount per week): ______________
Do you use recreational drugs? ☐ Yes ☐ No (If yes, specify type & amount per day): ____________
How would you rate your current level of stress? ☐ Low ☐ Average ☐ High ☐ Very High
Are you exposed to cigarette smoke on a regular basis? ☐ Yes ☐ No
Any significant exposure to mold you are aware of? ☐ Yes, currently ☐ Yes, in the past ☐ No
Any significant exposure to heavy metals or chemicals you are aware of? ☐ Yes, currently ☐ Yes, in the past ☐ No
What is your blood type? ☐ O ☐ A ☐ B ☐ AB ☐ Unknown
Do you have any dietary restrictions? ☐ Yes ☐ No
If yes, please specify (vegetarian, gluten free, dairy free, paleo, etc.): ____________________
Describe what you typically eat each day
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Fluid intake and amount (water, tea, juice, etc.): ____________________

ALLERGIES/MEDICATIONS

Please list any allergies (foods, drugs, environment) and allergic reactions to each (hives, difficulty breathing, etc.) ____

____

Please list any prescription drugs you are currently taking and dosage: ____________________

____

____

Please list any over-the-counter medications, vitamins, minerals, herbs, and other supplements you are currently taking and dosage: ____

____

____

____

Patient name: ______________________________ Birth date: ______________

SYMPTOMS

Select any symptoms you have experienced within the last six (6) months.

GENERAL
- ☐ Fatigue
- ☐ Insomnia
- ☐ Sleepiness during day
- ☐ Frequent fevers
- ☐ Night sweats
- ☐ Unintended weight loss

HEAD
- ☐ Headache
- ☐ Hair loss
- ☐ Trauma
- ☐ Dizziness
- ☐ Fainting

EYES
- ☐ Pain
- ☐ Vision changes
- ☐ Dry eyes

EARS
- ☐ Ringing in ear
- ☐ Hearing difficulty/loss
- ☐ Frequent earaches
- ☐ Ear discharge or popping

NOSE
- ☐ Post-nasal drip
- ☐ Sinus pain
- ☐ Runny nose
- ☐ Sneezing
- ☐ Nasal congestion
- ☐ Snoring
- ☐ Nosebleeds

MOUTH
- ☐ Bleeding gums
- ☐ Sores in mouth

THROAT
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Irregular heartbeat/palpitations
- ☐ Swelling of ankles
- ☐ Cold hands and feet

RESPIRATORY
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Wheezing

DIGESTIVE
- ☐ Heartburn/reflux
- ☐ Abdominal pains
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Painful elimination

URINARY
- ☐ Pain during urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Incontinence

WOMEN
- ☐ PMS
- ☐ Menstrual pain or cramps
- ☐ Irregular periods
- ☐ Heavy flow
- ☐ Spotting between periods
- ☐ Pain with intercourse
- ☐ Frequent yeast infections

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Muscle cramps

SKIN
- ☐ Acne
- ☐ Rashes
- ☐ Hives
- ☐ Bruise easily
- ☐ Slow wound healing

NEUROLOGICAL
- ☐ Restless legs
- ☐ Numbness or tingling

EMOTIONAL/MENTAL
- ☐ Depression
- ☐ Anxiety
- ☐ Mood swings
- ☐ Irritability
- ☐ Forgetfulness

ENDOCRINE
- ☐ Increased thirst
- ☐ Increased urination
- ☐ Heat intolerance
- ☐ Cold intolerance

IMMUNE
- ☐ Frequent colds
- ☐ Swollen lymph nodes

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Patient/guardian signature:______________________________ Date: ______________

Physician's signature: ______________________ Date reviewed with patient: ____________