Today's date: **PLEASE COMPLETE AND SIGN** New Patient ☐ Updated info: ☐

ACCOUNT# PATIENT INFORMATION FCOF RCOF

Last name: First name: Middle Initial: Marital status: Single ☐ Mar ☐ Partner ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? Social Security no.: Birth date: Age: Sex: ☐ M ☐ F

Street address (Mailing address for statements) City: State: Zip:

Email address: Evening phone no: ( )

Prefer to receive messages or coupons: Day# ☐ Evening# ☐ Email ☐ None ☐

Employer Daytime phone no.: ( )

Chose clinic because/referred to clinic by: ☐ Location ☐ Family ☐ Friend ☐ Insurance plan ☐ Physician ☐ Seminar or event ☐ Dex Yellow Pages ☐ Verizon Superpages ☐ Redirect guide ☐ Other

NAME OF PERSON WHO REFERRED YOU (if applicable):

We may require a credit card on file to receive discounted rates. Please include:

Credit card type: *Credit card number:* *Expiration:*

3-digit verification code:

PRIVATE HEALTH INSURANCE INFORMATION

(**Please give your insurance card to the receptionist**.)

Name of primary insurance: Address: City: State: ZIP Code:

Name of secondary insurance:

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-pay/insurance:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IF YOU HAVE A SECONDARY INSURANCE YOU WOULD LIKE US TO BILL PLEASE NOTIFY THE RECEPTIONIST.

MOTOR VEHICLE ACCIDENT OR WORKER'S COMPENSATION INSURANCE INFORMATION

☐ Work comp ☐ MVA (Please give your insurance card to the receptionist.)

Name of insurance plan: Address: City: State: ZIP Code:

Claim representative's name: Phone no.: ( ) Attorney's name: Phone no.: ( )

Date of injury: Claim number: Injured body part:

Employer at time of injury name:

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Phone no.: ( )

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance per the credit policies of the All Naturopathic Clinic. I also authorize the All Naturopathic Clinic or insurance company to release any information required to process my claims.

Patient or Guardian signature: Date:

Are you currently under the care of a medical professional? Yes No

If yes, please list the name of the facility and physician:

_____

Date of last physical/annual exam_____ **Date of last blood test** _____

Any ongoing diagnoses or abnormal lab values?

_____

What are your most important health concerns?

1. _____
2. _____
3. _____
4. _____
5. _____

Any past hospitalizations, serious illness and/or injuries?

_____

_____

Review of Systems:

Please list any symptoms you are currently experiencing in the following areas

Severity of current complaint(s) (0-best, 10-worst):

	Symptoms	Severity		Symptoms	Severity
Head:			Blood/Peripheral Vascular:		
Ears:			Gastrointestinal:		
Eyes:			Genito-Urinary:		
Nose:			Endocrine:		
Throat:			Neurological:		
Respiratory:			Musculo-Skeletal		
Mood/Psych:			Skin:		
Cardiovascular:			Other:		

Last menstrual period (♀): _____

Social History:
Please circle those that apply: Single Married Significant Other
Do you have any children? Yes No Year(s) of their births? _____
Occupation: _____

Prescriptions currently taking	Dosage	Supplements currently taking	Dosage

Personal Habits:
Please circle any of the following substances that you use regularly: Tobacco Coffee/black tea/cola
Alcohol Recreational drugs

Average Daily Diet:
Morning: _____

Afternoon: _____

Evening: _____

Snacks:_____Beverages:_____

Do you exercise regularly □ Yes □ No

If yes, what type? _____

How long? _____ How often? _____
Any known allergies? Drugs: _____
Inhalants: _____ Food:_____
Family History: Please check the "yes" box next to each condition that **applies to you or a family member**. Note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "Relationship" column.

	Yes	Relationship	Dates Resolved Past(P)Current (C)		Yes	Relationship	Dates Resolved Past(P)Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression/ Anxiety				Stroke			
Diabetes				Tuberculosis			
Eczema				Auto Immune Disease			
Epilepsy				Thyroid Disorder			

CONSENT FOR TREATMENT

Methods, Procedures, and Therapeutic Approaches: Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.
General Diagnostic Procedures: Including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments.
Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Topical Treatments and Prepping: anesthesia, liquid nitrogen
Herbs/Natural Medicine: Prescribing of various therapeutic substance including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, tinctures-may contain alcohol; topical crèmes, pastes, plasters washes; suppositories, or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.
Dietary Advice and Therapeutic Nutrition: use of foods, diet plans, or nutritional supplements for treatment-may includes intramuscular vitamin injections and intravenous therapy.
Soft tissue and Osseous Manipulation: use of massage, neuro-muscular technique, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction.
Electromagnetic and Thermal Therapies: includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, ionic footbath, and low volt galvanic therapies.
Minor Surgery procedures: removal of cysts, moles (nevi), lipomas, skin tags, and other skin lesions using medical devices such as hyfercator, cautery, and liquid nitrogen.
Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies; allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, and aggravation of pre-existing symptoms.
Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Notice to Pregnant Women: All female patients must alert the doctor if you know or suspect you are pregnant, since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating or inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

Terms of Admission

Financial Terms: I understand that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than me, is not authorized to receive my medical information unless expressly authorized by me in writing.

Notice of Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. The All Naturopathic Clinic is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully.

Cancellations and No Show: Please notify us if you are unable to make your appointment or make any changes within 24 hours of your appointment to avoid a late fee of **$20.**

X _____ _____
Patient Signature Date

X _____ _____
Guardian/Representative's Signature Date

X _____ _____
Relationship to Patient/Representative Authority Date