**Naturopathic New Patient Registration & Intake Form**

Please complete each area. Fields marked with an asterisk\* are required

**Health Concerns\* (Please list in order of importance)**

|  |
| --- |
| 1. |
| 2. |
| 3. |

|  |
| --- |
| Name (Last, First, MI.)\* |

|  |  |  |
| --- | --- | --- |
| DOB\* | Sex\* | SSN\* |

|  |  |
| --- | --- |
| Home PhoneCell Phone\* | Can we leave a message at this number? Y N Can we leave a message at this number? Y N |

|  |
| --- |
| Home Address:Mailing address (if different from Home Address)\* Email: |

|  |  |  |
| --- | --- | --- |
| Emergency Contact name\*: | Relationship\* | Phone Number\*: |
| How did you hear about us? | Preferred language: | Race/ethnicity: |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Is there anyone, other than your doctor with whom we can discuss your private health information? For example, your family may have questions regarding your care, billing or appointments?\* Y N

|  |  |  |
| --- | --- | --- |
| Authorized contacts name: | Relationship to patient | Phone Number: |
| Authorized contacts name: | Relationship to patient | Phone Number: |

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|  |
| --- |
| Occupation and Employer’s Name:Work Phone Number: |
| Is this exam due to a work related accident? |
| Employer’s Address: |

|  |
| --- |
| Current or Prior Primary care Physician’s Name:Phone Number: |

****Diet & Lifestyle Information:

|  |  |
| --- | --- |
| Exercise: What type of exercise and how often? | Diet: Restrictions? Patterns? |
| Sleep: How many hours of sleep per night? | Issues with sleep? |
| Drink alcohol? Y N | What kind? | How often? |
| Recreational Drugs? Y N | What Kind? | How often? |
| Smoke Cigarettes? Y N | Packs/day? | Ready to quit? |

|  |
| --- |
| If no known drug allergies, please check this box  |
| Please list you allergies to medications: |
| Please list any other allergies (food, seasonal, etc.?) |

**Medications/ Supplements/ Herbs\*** (List those you are currently taking) : Write extra med/supp on back of last page.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date Started** | **Reason** | **Dose** | **Effective? (Y/N)** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Hospitalization/ Surgeries/ Trauma\***

|  |  |
| --- | --- |
| **Year** | **Reason & Outcome** |
|  |  |
|  |  |
|  |  |

**Please check box to indicate if you or a family member has ever had any of the following conditions.** If the condition does not apply, please leave blank*. Please indicate which relative has the condition if applicable. For example, mother (m), Father (f), siblings (s), maternal/paternal Grandmother/Grandfather (MGM. MGF, PGM, PGF)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** | **Self** | **Relative** | **Condition** | **Self** | **Relative** |
| Allergies |  |  | HIV/AIDS |  |  |
| Anemia |  |  | Hypertension |  |  |
| Anxiety |  |  | Irritable Bowel syndrome |  |  |
| Arthritis |  |  | Kidney disease |  |  |
| Asthma |  |  | Meningitis |  |  |
| Blood Transfusion |  |  | Nerve/ muscle disease |  |  |
| Cancer |  |  | Osteoporosis |  |  |
| Cataracts |  |  | Parkinson’s/Alzheimer’s |  |  |
| Congestive heart failure |  |  | Seizures |  |  |
| Clotting disorder |  |  | Sickle cell anemia |  |  |
| COPD |  |  | Stroke |  |  |
| Depression |  |  | Substance abuse |  |  |
| Diabetes |  |  | Thyroid disease |  |  |
| Emphysema |  |  | Tuberculosis |  |  |
| GERD |  |  | Ulcers |  |  |
| Glaucoma |  |  | Other |  |  |
| Heart Attack |  |  | Other |  |  |
| Heart murmur |  |  | Other |  |  |

I certify that the information provided in this form is correct to the best of my knowledge. I will not hold Holistic Family Medicine Inc. (or its dependent contractor) responsible for any errors or omission I may have made in the completion of this form.

Patients Name (print) Signature Date

 ****

**Financial Agreement**

I, , being a patient of Dr. Laura Martin

located at *3525 Colby Ave. Ste. 244 Everett, WA* do hereby acknowledge that my health insurance policy is an arrangement between the Health Plan and myself.

**I understand that it is my responsibility to know and understand my insurance policy and its benefits.**

I understand that certain services may not be covered by my insurance under the terms of my policy. I understand that I am responsible for all bills incurred at this office and I agree to make financial arrangements with my practitioner to pay for any services not covered by my insurance policy.

Dated at (city) \_, Washington, this \_\_\_\_\_day of \_\_\_\_\_\_\_\_\_, 20\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient’s signature)

**Medical Insurance:\*** This section **MUST** be completed in addition to providing a current insurance card at the time of your visit. We cannot file a claim without an insurance card. If you have no health insurance check this box

|  |  |  |
| --- | --- | --- |
| Primary insurance Plan | Policy number |  |
| Policy holders name  | Date of birth | SSN |
| Secondary Insurance Plan  | Policy Number |  |
| Policy holders name  | Date of Birth  | SSN |

****Acknowledgement of Privacy Practices

Holistic Family Medicine

10333 19th Ave SE Suite 103

Everett, WA 98208

425-257-9713

My Signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Policy and Portability Act of 1996 (HIPPA); The details of this policy can be found in the Notice of Privacy Practices posted in the clinic waiting area. You may request a copy of this notice.

I understand that my protected information can and will be used to:

 Provide and coordinate my treatment among a number of health care providers

 who may be involved in my treatment directly and indirectly.

 Obtain payment from third party payers for health care services.

 Conduct normal health care operations, such as quality assessment and improvement activities.

I have been informed of Holistic Family Medicine’s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Practices. I understand that Holistic Family Medicine has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of this notice.

I understand that I may request in writing that Holistic Family Medicine restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that Holistic Family Medicine is not required to agree to my requested restrictions, but if Holistic Family Medicine does agree than they are bound to abide by such restrictions.

Patient Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (if the patient is a minor or other dependent) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dependent family members also covered by this acknowledgment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_