Green Circle Wellness New Patient Intake Form

PATIENT REGISTRATION

Last Name_____ First Name_____ M Initial_____

Address_____Apt._____

City_____State_____Zip Code_____

Cell Number_____E-mail Address_____

Referred By:_____Primary Care Physician_____

DEMOGRAPHICS

Preferred Language_____Race_____Ethnicity_____

PATIENT EMPLOYER INFORMATION

Employer_____Occupation_____

Address_____City_____State_____Zip Code_____

Work Phone_____

EMERGENCY CONTACT

Name_____Relationship_____

Home Phone_____Work Phone_____

PRIMARY INSURANCE INFORMATION

Insurance Company_____Group#_____Subscriber#_____

Guarantor Name_____Relationship_____DOB_____SSN#_____

Guarantor Address_____City_____State_____Zip Code_____

PHARMACY INFORMATION

Local Pharmacy_____ Phone_____Address_____

Mail Order Pharmacy (if applicable)_____Phone_____State_____

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Name_____Date of Birth_____Date_____

PRESENT ILLNESS

Height_____Weight_____Blood Pressure (if known)_____

Describe your present medical symptoms:_____

_____

_____

List all allergies – including any drugs (what was the reaction?):_____

_____

List your current medications (prescription, nonprescription drugs, birth control pills, supplements, and herbs):

Name	Dosage	How many times/day?

2) Previous significant medical problems/hospitalizations

Type of Surgery	Date	Where treated?

Have you ever had any problems in the following areas?

Circle one

Asthma Y/N
Attention Deficit Disorder Y/N
Allergies Y/N
Bladder Problems Y/N
Diabetes Y/N
Ear Infections Y/N
Epilepsy of Seizures Y/N
Eczema Y/N
HIV or AIDS Y/N
Kidney Problems Y/N
Large Intestine Problems Y/N
Liver Problems Y/N
Lung Problems Y/N
Menstrual Problems Y/N
Prostate Problems Y/N
Small Intestine Problems Y/N
Edema/Swelling Y/N
Frequent Cold/Flu Y/N
Gallbladder Problems Y/N
Headaches Y/N
Hepatitis Y/N
High/Low Blood Pressure Y/N

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FAMILY MEDICAL HISTORY

List any medical problems of the following blood relatives:

Father_____

Mother_____

Siblings_____

SOCIAL HISTORY

Occupation_____

Current or previous smoker?_____How much?_____For how many years?_____ Quit? Y/N

Do you drink alcohol?_____Drinks of wine/beer/hard liquor per day/week:_____

Do you use recreational drugs?_____If so, what type?_____

Do you exercise regularly?_____What dietary guidelines do you follow?_____

Do you have any risks for HIV exposure?
Blood transfusion? Y/N
IV Drug Use? Y/N
Multiple sex partners? Y/N
NONE

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REVIEW OF SYSTEMS

Do you have any unusual:

Fevers? Y/N
Night Sweats? Y/N
Chills? Y/N
Fatigues? Y/N
Have you gained/lost more than 10lbs. in 6 months? Y/N

RESPIRATORY
Persistent cough? Y/N
Sputum/Phlegm Production? Y/N
Shortness of breath? Y/N
Coughing up blood? Y/N

CARDIAC
Shortness of breath with minimal activity? Y/N
Shortness of breath when lying flat? Y/N
Swelling of legs? Y/N
Are you ever awakened from sleep with shortness of breath? Y/N
Do you have any chest pain or discomfort? Y/N
Palpitations? Y/N

GASTROINTESTINAL
Any abdominal pain? Y/N
Bloating/Swelling? Y/N
Nausea? Y/N
Vomiting? Y/N
Diarrhea? Y/N
Constipation? Y/N
Blood in your stool? Black Tarry Stools? Y/N
Have your bowel habits changed? Y/N

URINARY
Any burning with urination? Y/N
Too frequent urination? Y/N
Awakened from sleep to urinate? Y/N How often?_____
Any blood in the urine? Y/N
Trouble starting urination? Y/N
Any history of STD's? Y/N
If so, what kind of STD?_____
(Gonorrhea, Chlamydia, Syphilis, Genital Warts, Herpes, HPV)
Unusual vaginal discharge or bleeding? Y/N

NEUROLOGICAL
Any unusual headaches? Y/N
Loss of vision or double vision? Y/N
Weakness or numbness in the arms or legs? Y/N
Dizziness? Y/N

MUSCOLOSKELETAL
Bone or joint disease? Y/N
Tendonitis? Y/N
Bursitis? Y/N
Bone Fractures? Y/N
Arthritis? Y/N
Sprains? Y/N
Headaches/head injuries? Y/N
TMJ/Jaw Pain Y/N
Herniated/Slipped Disk? Y/N
Low back/Hip/Leg Pain? Y/N
Neck/Shoulder/Arm Pain? Y/N
Any persistent joint ache or swelling? Y/N
Which joints involved?_____

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GYNECOLOGICAL

Total Pregnancies?_____ Any miscarriages? Y/N Abortions? Y/N
Do you have breast implants? Y/N Date of your last menstrual period?_____
Are your periods regular? Y/N Do you menstruate excessively? Y/N
Unusual vaginal discharge or bleeding? Y/N Are you in menopause? Y/N
What type of birth control method do you use?_____When was your last pap smear?_____
When was your last mammogram?_____

DIGESTIVE

How many meals do you eat per day?_____How would you describe your appetite?_____
Describe any cravings:_____Describe any aversions_____

Briefly describe your diet:_____

_____

_____

Do you have any restrictions? Y/N_____ Food Allergies?_____
Hypoglycemia? Y/N

MENTAL HEALTH

Do you feel like you have control over your life? Y/N Do you have low energy? Y/N
Do you have chronic problems with sleep? Y/N
Do you have a difficult time dealing with your chronic illness or illness in your family? Y/N
Are you experiencing conflict with interpersonal relationships? Y/N
Have you felt irritable, tense, or anxious over the past week? Y/N
Have you felt sad or blue over the past week? Y/N
Do you use substances (alcohol, caffeine, pills) to help you cope with difficult situations? Y/N

EXERCISE

Do you exercise regularly? Y/N What type of exercise?_____
How many times a week do you exercise?_____ How long do you exercise?_____
Do you meditate? Y/N How often?_____

Do you have any symptoms not described above?_____

_____

_____

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Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf.

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations. Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
5. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

I understand that Green Circle Wellness is not a Primary Care Practice, and all alternative therapies can be complementary but do not serve to substitute for conventional therapies. Patients are still obligated to do routine checkups with their primary care physicians, perform regular mammograms, pelvic exam/pap smear, prostate exam, colonoscopy, cardiac work up and other tests suggested by their primary care physicians.
I understand that only the physician is practicing medicine and prescribing any type of pharmaceuticals. I recognize that all non-physician providers are facilitating my health and well-being within the scope of their training and any licenses, and do not diagnose illness. I also understand that for any procedures that may involve needles (such as intra-muscular and sub-cutaneous injections and IV infusions) and minor surgical procedures, Green Circle Wellness will utilize sterilized equipment and single-use, disposable needles.

Initial_____

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Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge $25 for missed appointments or appointments canceled without any advanced notifications within 24 hours prior to your appointment, by phone or email. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees for services and products, as well as legal fees, collection agency fees, and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician. The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) on file, supplied by patient to the practice for current and future charges, when incurred. We will email you a receipt for any charges to your credit or debit card, unless you specify you do not wish them to be sent through the email.

Initial_____

Communication:

I understand that in case of medical emergency I will immediately contact my primary physician or dial 911. Any adverse reactions to the treatment, administered or recommended by Green Circle Clinic should be reported to us in the timely manner.

Email usage and confidentiality notice: I understand and agree that e-mail is not an appropriate means of communication regarding an emergency or other time sensitive issues or inquiries regarding private information. If the Patient does not receive a response to an e-mail message within 24 hours, she/he agrees to contact the Physician by other means.

E-mail is not necessarily a secure medium for sending or receiving PHI and there is always a possibility that a third party may gain access. Your transmission of information in this medium signal your understanding and agreement that confidentiality cannot be guaranteed.

First/Last Name (Print)_____

Signature_____

Date_____