Upper Valley Natural Health Center

Patient Registration Form

Patient Information

Last Name: ______________________ First Name: ______________________ MI: ____

Previous Name: ______________________ Date of Birth: ______________ Gender: ____

Mailing Address: ______________________ Street Address: ______________________

City: ______________________ State: ________ Zip: __________

Employer/School: ______________________ E-mail Address: ______________________

Cell Phone: ______________ Home Phone: ______________ Work Phone: ______________

Emergency Contact: ______________________ Contact's Phone(s): ______________________

Emergency Contact is my: (specify relationship) ______________________

How did you hear about us? ❑ *Friend/Family* ❑ *Medical Referral* ❑ *Newspaper Ad* ❑ *Website* ❑ *Yellow Pages*

Responsible Party Information if someone other than the patient is financially responsible for the patient's account.

Name: ______________________ Phone: ______________________

Street Address: ______________________

City: ______________________ State: ________ Zip: __________

Insurance Information Please provide your insurance card(s) for photocopying.

Primary Insurance Company: ______________________ Insurance Phone: ______________________

Subscriber's Name: ______________________ Subscriber's Date of Birth: ______________________

Patient's Relationship to Subscriber: (check one) ❑ *Self* ❑ *Spouse* ❑ *Child*

Secondary Insurance Company: ______________________ Insurance Phone: ______________________

Do you have a **Health Savings Account (HSA)** or **Health Reimbursement Arrangement (HRA)**? ______________

Payment is expected at the time of service.

This includes amounts due for insurance co-pays and any natural medicines dispensed.

Telephone / email consultations and labs not covered by insurance are the patient's responsibility.

We accept cash, personal checks and credit cards (MasterCard, Visa, American Express, Discover.)

Returned Checks: There will be a charge of $25 for each returned check.

Cancellations: Please provide at least 24 hours advance notice if an appointment needs to be rescheduled or cancelled.
There is a $50 charge for missed appointments or late cancellations.

(OVER)

Upper Valley Natural Health Center

Contact Preferences

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). Individuals have the right to request receipt of confidential communications from us by alternative means or at alternative locations.

I wish to be contacted in the following manner: (check all that apply)

Telephone Communication: appointment reminders, requests to call office on billing or medical matters

Cell Phone: ___________________________________

- ❑ OK to leave message with detailed information
- ❑ Leave office name and call-back number ONLY

Home Phone: _________________________________

- ❑ OK to leave message with detailed information
- ❑ Leave office name and call-back number ONLY

Work Phone: _________________________________

- ❑ OK to leave message with detailed information
- ❑ Leave office name and call-back number ONLY

Written Communication: appointment reminders, lab results, billing statements

- ❑ Mail to my home address
- ❑ Do NOT mail to home address. Please mail to:

____

____

Email Communication: administrative matters (supplement re-orders, etc.), conversations with physician via email regarding my health care

Email address: ________________________________

- ❑ OK for administrative use
- ❑ OK for medical consultations

I understand that information sent via email is not considered secure and may result in the accidental disclosure of personal health information.

____

Signature of Patient

____

Patient's Name (PRINT)

____

Date

(OVER)

For Office Use Only: Record of Disclosures						
Date	Disclosed to Whom	Authorized	Purpose	By Whom Disclosed	Type	Method

Type key: T=Treatment Records, P=Payment Information, O=Healthcare Operations; A=Authorization on file; D=Discretionary

UPPER VALLEY NATURAL HEALTH CENTER

Patient Agreement

Please initial each section of this agreement and sign at the end.

CONSENT TO CARE **PATIENT INITIALS: ____**

You are the most important person on your health care team. You are entitled to receive clear and understandable information about the treatment options for your health concerns.

I wish to be treated by the health care provider(s) at Upper Valley Natural Health Center. I understand that this care may include any of the following procedures and therapies as necessary to properly evaluate, diagnose and treat my health concerns: physical exams; diagnostic imaging (X-rays, ultrasound, etc.); venipuncture, Pap smears and other specimen collection for diagnostic labwork; dietary and lifestyle counseling; botanical medicines, homeopathic medicines, nutrient therapy (including oral, intramuscular injection or intravenous infusion); soft tissue and bony manipulations; hormonal therapies and prescription medications.

I understand that I may ask questions regarding my individual treatment and that I am free to refuse any specific procedure or treatment or to terminate care at any time. I have the right to seek a second opinion from another health care professional. With this knowledge, I consent to the routine evaluation and treatment deemed necessary or advisable by the health care provider(s) responsible for my care, realizing that no guarantees have been given to me by Upper Valley Natural Health Center.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION **PATIENT INITIALS: ____**

I agree to authorize Upper Valley Natural Health Center to use and/or disclose my health information as necessary to treat me, to obtain payment for services, and to conduct other internal health care operations as described in the Notice of Privacy Practices.

In addition, I authorize Upper Valley Natural Health Center to disclose my protected health information (PHI) and/or discuss my care with the following specific individuals:

Physicians:____

Other Healthcare Practitioners: ____

Family Members or other Individuals: ____

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS **PATIENT INITIALS: ____**

If I have health care insurance, I agree that Upper Valley Natural Health Center (UVNHC) may bill these insurers and they may make their payments directly to UVNHC. I understand that I am liable to UVNHC for all related charges, whether or not covered by insurance, and the amount I am charged by UVNHC will be based on the benefits of my individual policy.

STATEMENT OF FINANCIAL RESPONSIBILITY **PATIENT INITIALS: ____**

I acknowledge that I am legally responsible for all charges for the services provided to me by Upper Valley Natural Health Center to the extent that those charges are not covered or paid by my insurance carrier/health plan or other payment source such as Medicare or Medicaid. I understand that my insurance carrier/health plan may not approve or pay for the medical services provided by Upper Valley Natural Health Center. I understand that I am personally responsible for payment of all charges not paid in full, co-payments, policy deductibles, and co-insurance, *except where my liability is limited by contract or State or Federal law*. **(OVER)**

NON-COVERED AND/OR NON-MEDICALLY NECESSARY SERVICES

PATIENT INITIALS: ____

I acknowledge that I am legally responsible for all charges associated with the provision of non-covered and/or non-medically necessary services. I understand Upper Valley Natural Health Center is not responsible for ensuring that I understand which services are not covered or are not considered medically necessary by my insurance carrier/health plan *except where required by contract or State or Federal law*. I understand it is my responsibility to review my insurance plan benefits and accept responsibility for payment should I choose to proceed with care.

PATIENT POLICIES

PATIENT INITIALS: ____

I acknowledge that I have received and understand the policies for patients as written in the Welcome Letter.

____
Signature of Patient

____
Patient's Name (PRINT)

____
Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of Upper Valley Natural Health Center's Notice of Privacy Practices that outlines the types of uses and disclosures that may occur involving my protected health information, describes my rights, and explains how I may exercise those rights. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that if I have questions or complaints, I may contact the Upper Valley Natural Health Center at 802-281-6989. I also understand that I am entitled to receive updates upon request if Upper Valley Natural Health Center amends or changes its Notice of Privacy Practices in a material way.

____
Signature of Patient

____
Patient's Name (PRINT)

____
Date

FOR OFFICE USE ONLY: Unable to Obtain Acknowledgement of Receipt

This section serves as a record of Upper Valley Natural Health Center's good faith effort to obtain written acknowledgement from the patient of receipt of the Notice of Privacy Practices. Patient was given a copy of the notice on: __________________.

- ❑ Patient refused to sign acknowledgement.
- ❑ Patient is physically unable to sign acknowledgement.
- ❑ Other: ____

UPPER VALLEY NATURAL HEALTH CENTER

Adult Health History

Last Name: ______________________________ First Name: ______________________ MI: ____

Preferred Name: _____________________ Date of Birth: ______________ Age:______ Gender:___

Present Health Concerns: *Please list your top 2 health concerns, including date of onset and severity.*

1. ____
2. ____

What do you believe is causing your most important health concerns? ______________________________

____

What goals do you have for your visit today? ____

____

Healthcare Practitioners: *Please list your current medical practitioners with their contact information.*

	Practitioner's Name	Office Name	City	Phone
Primary Care				
OB/Gyn				
Pharmacy				

Medications: *Please list all prescription drugs and over-the-counter medications that you are currently taking, including supplements (vitamins, minerals, nutrients, herbs, homeopathic remedies, etc.).*

Medication/Supplement	Reason	Date began	Dose/Timing

Allergies: *Please list and describe any severe or life-threatening allergies (medications, stings, foods, etc.):*

❍ NONE or ____ **(OVER)**

Review of Systems: *Check ☑ symptoms that you* *<u>currently</u>* *experience.*

Constitutional	Heart & Circulation	Stomach & Digestion	WOMEN: Reproductive
Max weight: _____ Year: ____	❍Heart murmur	❍Bad breath	Last menstrual period: ______
Min weight: ______ Year: ____	❍Irregular heartbeat	❍Excessive thirst	Age period started: ______ yrs
❍Appetite change	❍Heart palpitations	❍Difficulty swallowing	Length of flow: _______ days
❍Weight change	❍Chest pain	❍Indigestion	Length of cycle: _______ days
❍Fevers *or* Chills	❍Lightheaded	❍Belching	# Pregnancies: _______
❍Sweats	❍Fainting	❍Heartburn *or* Reflux	# Live births: _______
❍Feeling hot *or* cold	❍Deep leg pain on walking	❍Nausea	# Miscarriages: _______
❍Fatigue	❍Varicose veins	❍Vomiting	# Abortions: _______
❍Weakness	❍Swelling of feet / ankles	❍Abdominal pain *or* cramping	Last Pap smear: ___________
Eyes	❍Cold hands *or* feet	❍Gas *or* Bloating	Last Mammogram: _________
❍Eye pain	❍Easy bruising	# Bowel movements/ day: ____	Last Bone scan: ___________
❍Poor night vision	**Chest & Lungs**	❍Constipation	❍Irregular menstrual cycle
❍Glasses *or* Contacts	❍Shortness of breath: At rest	❍Loose stools *or* Diarrhea	❍Bleeding between periods
❍Blurred *or* Double vision	Walking Lying down	❍Mucus in stool	❍Heavy periods
❍Cataracts *or* Glaucoma	❍Wheezing *or* asthma	❍Blood in stool	❍Painful periods
❍Dry eyes	❍Cough: wet *or* dry	❍Anal pain *or* itching	❍Premenstrual syndrome
Ears, Nose, Mouth, Throat	❍Breast lump *or* pain	❍Hemorrhoids	❍Pelvic pain
❍Ringing in ears	❍Nipple discharge	❍Hernia	❍Abnormal pap smear
❍Earaches	❍I do self breast exams	❍Jaundice	❍Vaginal discharge
❍Itchy ears	**Neurological**	**Muscles & Joints**	❍Vaginal itching *or* soreness
❍Excessive ear wax	❍Dizziness	❍Neck pain	❍Sores on genitals
❍Hearing loss *or* hearing aid	❍Poor balance	❍Back pain	❍Infertility
❍Nosebleeds	❍Poor coordination	❍Morning stiffness: ____ hours	❍Sexual difficulties
❍Stuffy *or* Runny nose	❍Tremors *or* shaking	❍Joint Pain: *indicate* **R** *or* **L**	❍Pain with intercourse
❍Postnasal drip	❍Seizures	❍ wrist ❍fingers	❍Menopausal symptoms
❍Sinus problems	❍Headaches	❍ elbow ❍shoulder	❍Hormone Replacement
❍Change in taste *or* smell	❍Numbness *or* tingling	❍ hip ❍knee	**MEN: Reproductive**
❍Snoring *or* Sleep apnea	❍Nerve pain	❍ ankle ❍foot	❍Sores on genitals
❍Teeth *or* Gum problems	❍Memory loss	❍Joint swelling	❍Discharge
❍Dentures	❍Brain fog	❍Joint replacements	❍Testicle lump/swelling/pain
❍Grinding teeth	❍Poor concentration	❍Muscle pain	❍Prostate problems
❍Mouth sores	❍Hyperactivity	❍Muscle weakness	❍Infertility
❍Dry mouth	❍Impulsivity	❍Muscle cramps	❍Sexual difficulties
❍Sore throat	❍Changes in speech	**Skin, Hair, Nails**	❍I do self testicular exams
❍Hoarseness	**Mental & Emotional**	❍Acne	**Bladder & Kidney**
❍Lump in throat	❍Mood swings	❍Dry skin *or* Itchy skin	❍Frequent / Urgent urination
❍Jaw clicking *or* pain	❍Anger, frustration, irritability	❍Rashes *or* Hives	❍Painful urination
Immune System	❍Sadness *or* depression	❍Flushing *or* Discoloration	❍Blood *or* Pus in urine
❍Frequent infections	❍Suicidal thoughts	❍Moles *or* Growths	❍Recurrent infections
❍Sensitivity to foods	❍Anxiety *or* worry	❍Poor wound healing	❍Waking to urinate
❍Sensitivity to chemicals	❍Phobias	❍Hair loss	❍Interrupted flow
❍Lymph gland swelling / pain	❍Insomnia *or* disrupted sleep	❍Nail problems	❍Loss of bladder control

Past Medical History: *Please list the date of or age at each event.*

Serious Illnesses and Injuries: ____________________

Surgeries: ____________________

Hospitalizations: ____________________

Date of last annual physical: ______________ Blood tests: ______________ Colonoscopy: ______________

Childhood Illnesses: *Please check all that apply:* Your health as a child was: ❑ Good ❑ Fair ❑ Poor

❍ Chicken Pox	❍ Measles	❍ Pneumonia	❍ Scarlet Fever
❍ Diphtheria	❍ Mononucleosis	❍ Polio	❍ Strep Throat
❍ Ear Infections	❍ Mumps	❍ Rheumatic Fever	
❍ German Measles	❍ Whooping cough	❍ Tonsillitis	

Personal and Family Medical History: *Check ☑ each condition that applies to you and your biological family.*

KEY: P=Paternal; **M**=Maternal **GF**=Grandfather; **GM**=Grandmother	YOU	Parents		Grandparents				Siblings or Children				
		Mom	Dad	MGM	MGF	PGM	PGF					
Current Age / Age at Death ⇨												
☑ **Check if DECEASED** ⇨		❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Anemia												
Bleeding *or* Clotting Disorder												
Seasonal Allergies												
Eczema												
Asthma												
COPD / Emphysema												
Diabetes												
Thyroid disorder												
Osteoporosis												
Arthritis / Joint Disease												
Autoimmune Disease												
Celiac Disease												
Crohn's Dis. / Ulcerative Colitis												
Liver Disease / Hepatitis												
Gall Bladder Disease												
Kidney Stones *or* Disease												
Heart Attack / Heart Disease												
High Blood Pressure												
High Cholesterol												
Stroke												
Migraines												
Epilepsy *or* Seizures												
Alzheimer's *or* Dementia												
Tobacco / Alcohol / Drug Abuse												
Disordered Eating *or* Exercising												
Abuse *or* Trauma												
Anxiety / Panic Attacks / PTSD												
Depression / Suicide attempt												
Schizophrenia												
Cancer *(what type?)*												
Agricultural *or* Toxin Exposure												
Other:												

Social History

Marital status: ❍ Single ❍ Significant Other ❍ Married / Civil Union ❍ Divorced ❍ Widowed

\# Years: ____ My relationship is: ❍ Physically Unsafe ❍ Emotionally Unsafe ❍ Loving ❍ Supportive

Do you have any children? ❍ Yes ❍ No Please list their age(s): ______________________________

Household: ❍Alone ❍Roommate(s) ❍Spouse/Significant Other ❍Children ❍Grandchildren ❍Parent(s)

Education level: ❍High school ❍ College ❍ Graduate school ❍ Other: ______________________

Occupation: ❍ Student ❍ Work ❍ Homemaker ❍ Unemployed ❍ Volunteer ❍ Retired ❍ Disability

School/Job(s): ______________________________________ Hours per week: ____________

Memories of your childhood: ❍ Mostly happy ❍ Mostly painful ❍ Normal ❍ Don't recall

Do you find your life: ❍ Unsatisfactory ❍ Too demanding ❍ Boring ❍ Satisfactory ❍ Wonderful

Lifestyle and Personal Habits:

What are your primary sources of stress? ____

How much does stress impact your life? ________________ Hours of play & relaxation per week? _____

How do you manage stress and take care of yourself? ____

Are you:

Currently sexually active? ❍Yes ❍No Partners: # ___ ❍Male ❍Female Contraception: _______

Satisfied with your sex life? ❍Yes ❍No If no, why? ________________________________

Satisfied with your social life? ❍Yes ❍No If no, why? ________________________________

Satisfied with your spiritual life? ❍Yes ❍No If no, why? ________________________________

Satisfied with your work? ❍Yes ❍No If no, why? ________________________________

Do you:

Exercise regularly? ❍Yes ❍No If no, why? ________________________________

Which activities? ____

Sleep soundly and wake rested? ❍Yes ❍No If no, why? ________________________________

Use tobacco? ❍Yes ❍No ❍Quit date _______ Total years: ______ Amount /day: ____

Drink alcohol? ❍Yes ❍No ❍Quit date _______ Type: _________ Drinks /week: ______

Use non-prescribed drugs? ❍Yes ❍No ❍Quit date _______ Type: ___________ How often: ______

Drink caffeinated beverages? ❍Yes ❍No Type? __________________________ Drinks /day: ______

Diet: *Please give examples of your typical meals.*

Breakfast *Time*:_______	Lunch *Time*:_______	Dinner *Time*:_______	Snacks *Times*:________

List any dietary restrictions: ____

Protein Sources: ❍ Beef ❍ Pork ❍ Poultry ❍ Fish ❍ Shellfish ❍ Eggs ❍ Dairy ❍ Soy ❍ Beans ❍ Nuts

How often do you eat out? _________________ What are your food cravings? ____________________

Water: ________ ounces per day Other beverages: ____

This form has been reviewed by the physician with the patient.

____

Physician Signature Date