UPPER VALLEY NATURAL HEALTH CENTER

Adolescent Patient Registration Form

This registration form is to be completed by a parent, guardian, or other legal representative of the patient.

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) ____

Mother's Name: __________________________________ Father's Name: _________________________________

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

RESPONSIBLE PARTY INFORMATION please identify the person(s) financially responsible for the patient's account.

Name:____Phone: _______________________________

Street Address: ____

City: ______________________________ State: _______ Zip:____________

HEALTH 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.

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.

____
Patient's Name (PRINT)

____
Signature of Parent / Guardian / Representative

____
Name of Patient's Parent / Guardian / Representative (PRINT)

____
Relationship to Patient

____
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 **Parent/Guardian Initials: ____**

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 and intramuscular injection); soft tissue and bony manipulations; hormonal therapies and prescription medications.

I am entitled to receive clear and understandable information about the treatment options for my health concerns. 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 **Parent /Guardian 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 **Parent /Guardian 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 **Parent /Guardian 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 **PARENT /GUARDIAN 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 **PARENT /GUARDIAN INITIALS: ____**

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

____
Patient's Name (PRINT)

____
Signature of Parent / Guardian / Representative

____
Name of Patient's Parent / Guardian / Representative (PRINT)

____
Relationship to Patient

____
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.

____
Patient's Name (PRINT)

____
Signature of Parent / Guardian / Representative

____
Name of Patient's Parent / Guardian / Representative (PRINT)

____
Relationship to Patient

____
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

Adolescent 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				
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

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

Serious Illnesses and Injuries: ____

Surgeries: ____

Hospitalizations: ____

Date of last physical: ____________________ Date of last blood tests: ____________________

Allergies: *please list any severe or life-threatening allergies to medications, stings, foods, etc.:*

❍ NONE or ____ **(OVER)**

Review of Systems: *Check ☑ the symptoms that you* currently *experience. (To be filled out with/by the patient.)*

Constitutional	**Heart & Circulation**	**Digestion & Intestine**	**Female 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
❍ Abnormal weight change	❍ Chest pain	❍ Indigestion	Length of cycle: _______ days
❍ Fevers *or* Chills	❍ Lightheaded	❍ Belching	# Pregnancies: _______
❍ Sweats	❍ Fainting	❍ Heartburn *or* Acid Reflux	# Live births: _______
❍ Feeling hot *or* cold	❍ Cold hands *or* feet	❍ Nausea	# Miscarriages: _______
❍ Fatigue	❍ Swelling of feet / ankles	❍ Vomiting	# Abortions: _______
❍ Weakness	❍ Easy bruising	❍ Abdominal pain *or* cramping	Last Pap smear: ___________
Eyes	❍ Blood transfusions	❍ Gas *or* Bloating	❍ Irregular menstrual cycle
❍ Eye pain	**Chest & Lungs**	# Bowel movements/ day: ____	❍ Bleeding between periods
❍ Blurred *or* Double vision	❍ Shortness of breath	❍ Constipation	❍ Heavy periods
❍ Glasses *or* Contacts	At rest Walking Lying down	❍ Loose stools *or* Diarrhea	❍ Painful periods
Near *or* Far sighted	❍ Wheezing *or* asthma	❍ Mucus in stool	❍ Premenstrual syndrome
❍ Dry eyes	❍ Cough: wet *or* dry	❍ Blood in stool	❍ Pelvic pain
Ears, Nose, Mouth, Throat	❍ Breast lump *or* pain	❍ Rectal pain/itching	❍ Abnormal pap smear
❍ Ringing in ears	❍ Nipple discharge	❍ Hemorrhoids	❍ Vaginal discharge
❍ Earaches	❍ I do self breast exams	❍ Hernia	❍ Vaginal itching or soreness
❍ Itchy ears	**Neurological & Cognitive**	❍ Jaundice	❍ Sores on genitals
❍ Excessive ear wax	❍ Dizziness	**Muscles, Bones & Joints**	**Male Reproductive**
❍ Hearing loss *or* hearing aid	❍ Poor balance	❍ Neck or Back pain	❍ Sores on genitals
❍ Nosebleeds	❍ Poor coordination	❍ Joint Pain: *indicate* **R** *or* **L**	❍ Discharge
❍ Stuffy *or* Runny nose	❍ Tremors *or* shaking	❍ wrist ❍ fingers	❍ Testicle lump/swelling/pain
❍ Postnasal drip	❍ Seizures	❍ elbow ❍ shoulder	❍ I do self testicular exams
❍ Sinus problems	❍ Headaches	❍ hip ❍ knee	**Bladder & Kidney**
❍ Change in taste *or* smell	❍ Numbness *or* tingling	❍ ankle ❍ foot	❍ Frequent / Urgent urination
❍ Dental cavities	❍ Nerve pain	❍ Joint swelling	❍ Painful urination
❍ Grinding teeth	❍ Poor memory	❍ Morning stiffness: ___hours	❍ Blood or pus in urine
❍ Gum problems	❍ Poor concentration *or* focus	❍ Joint replacements	❍ Recurrent infections
❍ Mouth sores	❍ Spaciness *or* distractibility	❍ Muscle pain	❍ Waking to urinate
❍ Dry mouth	❍ Hyperactivity	❍ Muscle weakness	❍ Interrupted flow
❍ Jaw clicking *or* pain	❍ Impulsivity	❍ Muscle cramps	❍ Kidney stones
❍ Sore throat	❍ Learning disability	**Skin, Hair, Nails**	**Safety**
❍ Hoarseness	**Mental & Emotional**	❍ Acne	❍ I wear a seatbelt
❍ Lump in throat	❍ Mood swings	❍ Itching *or* Dry skin	❍ I wear bike/ski/skate helmet
Immune System	❍ Anger, frustration, irritability	❍ Rashes *or* Eczema	❍ There are guns or weapons at home
❍ Frequent infections	❍ Sadness *or* depression	❍ Hives	
❍ Allergies to environment	❍ Suicidal thoughts	❍ Moles *or* growths	I have trouble or feel unsafe at: ❍ Home ❍School ❍Work
❍ Sensitivity to foods	❍ Self-harm (cutting, etc.)	❍ Poor wound healing	
❍ Sensitivity to chemicals	❍ Anxiety, worry or phobias	❍ Hair loss	❍ I feel unhappy @ my looks
❍ Lymph gland swelling / pain	❍ Insomnia *or* disrupted sleep	❍ Nail problems	❍ I have 1 adult I can talk to

Childhood Illnesses: *Please check all that apply.* As a child, your health was: ❍ Good ❍ Fair ❍ Poor

❍ Chicken Pox
❍ Diphtheria
❍ Ear Infections
❍ German Measles (Rubella)
❍ Measles
❍ Mononucleosis (Mono)
❍ Mumps
❍ Pertussis (whooping cough)
❍ Pneumonia
❍ Polio
❍ Rheumatic Fever
❍ Tonsillitis
❍ Scarlet Fever
❍ Strep Throat (recurrent)

Immunizations: ❍ All immunizations up to date ❍ Delayed schedule ❍ Refused all immunizations

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

		Parents		Grandparents				Siblings				
	YOU	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?)*												
Other:												

This page is to be filled out with or by the patient.

Social History

Parents: ❍ Biological ❍ Adoptive ❍ Foster ❍ Step-parent(s)

Parents' Marital Status: ❍ Single ❍ Significant Other ❍ Married / Civil Union ❍ Divorced ❍ Widowed

Mother's Occupation:_____________ Full *or* Part Time Father's Occupation:__________ Full *or* Part Time

Siblings: ❍ *Yes* ❍ *No* Please list their age(s) ______________________________

Household: ❍ Parent(s) ❍ Sibling(s) ❍ Grandparent(s) ❍ Other ______________________

Romantic Relationship: ❍ Single ❍ Significant Other for ____ years

My relationship is: ❍ Physically Unsafe ❍ Emotionally Unsafe ❍ Safe and Supportive

School / Training Program: ______________________ Current grade level: __________

Non-Academic Activities: ❍ Sports ❍ Work ❍ Volunteer ❍ Other ____________________

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

My life is: ❍ 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 Age of 1st Sexual Activity: ____ Current # of Partners: _____

My partner(s) is/are: ❍ Male ❍ Female Form of Contraception/STI protection: ______________

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

Satisfied with school/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: ______ Amt. /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 describe your typical meals*. Dietary restrictions: ______________________

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

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 doctor with the patient and parent/guardian.

____

Physician Signature Date