MOUNTAIN VIEW NATURAL MEDICINE

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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name:_____ Preferred name: _____ Date of Birth:_____

Family: Race: _____ Ethnicity:_____Parent(s)/Legal Guardian(s):_____

Street Address:_____City/State/Zip:_____

Who else lives here? (circle): no one, spouse, partner, roommates. Other: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____. Can we leave a medical msg at home? Y/N. work? Y/N. cell? Y/N

What is your birth sex? (circle) M / F Other (specify) _____Marital Status: _____

What gender do you identify as? (circle) M / F Other (specify) _____ Referred by:_____

Emergency contact: _____ Phone: _____

Pharmacy (include city):_____ How would you like to receive apt reminders? Email/Phone

The language I best communicate in (circle one): English / French / Spanish / German / Nepali / other: _____

Do you have special communication needs? (i.e. translation, hearing impaired) _____

GUARANTOR

Name:_____ Relationship to patient:_____

Address (if different):_____Phone:_____

INSURANCE INFORMATION

Insurance Company:_____Subscriber:_____

Address:_____ Subscriber DOB:_____

Patient ID#:_____ Subscriber ID#:_____

Group #:_____ Patient's Relationship to Subscriber:_____

Subscriber's Employer / Address /Phone:_____

I authorize the release of any medical or other information necessary to process claims to my insurance carrier. I also request payment of government benefits either to myself or to the party who accepts assignment: Mountain View Natural Medicine. I authorize payment of medical benefits to Mountain View Natural Medicine for services rendered at this clinic and submitted to my insurance carrier.

_____

Signature Date

Would you like us to be your primary care provider? Y / N

Name of other or prior PCP (Primary Care Provider) if applicable: _____

Please list your health concerns in order of priority along with other practitioners you may be seeing for the condition:

1._____

2._____

3._____

4._____

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

PAST MEDICAL HISTORY: PLEASE LIST ANY SURGERIES AND/OR MAJOR ILLNESSES:

Age or date:	Description:

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications:	Reason:	Dose	Date began

Supplements:	Reason:	Dose	Date began

**Please list any drug allergies: _____

**Please list any food allergies_____

**Please list any environmental allergies: _____

Patients often desire communication between their healthcare providers. Do we have your permission to communicate verbally and in writing with other providers regarding your healthcare?
yes / no

FAMILY HEALTH HISTORY: (be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, mental health and substance or drug abuse histories)

Member	Living?/Age	Major illness or chronic conditions
Mother		
Father		
Siblings		
Mat. Grandmother		
Mat. Grandfather		
Pat. Grandmother		
Pat. Grandfather		

PREVENTATIVE HEALTH:
Please fill in what you can:

	Recent	Past year	Past 5 years
Weight			
Height			
Cholesterol w/ HDL & LDL			
Blood pressure			

If tested in the past 2 years, please check:
Thyroid (normal? y/n) _____ Blood sugar (normal? y/n) _____ Anemia (normal? y/n) _____
Date of last: Tetanus shot _____ Colonoscopy _____ (normal? y/n)

DIET: Please describe a typical day's diet for you, (be honest).

Breakfast	Lunch	Dinner	Snacks (what hour)

CURRENT HEALTH CONCERNS (Review of Systems) Please check normal or Abn and explain.

N ABN

__ __ Constitutional (Energy, weight, body temperature, sleep, general sense of well-being) _____
_____
__ __ Head: headaches, vertigo, injuries etc.)_____
__ __ Vision/eye problems: _____
__ __ Ear/nose/throat/mouth (allergies, infections etc.)_____
__ __ Cardiovascular: (high BP, cholesterol etc.) _____
__ __ Respiratory_____
__ __ Digestive tract issues: (changes in bowel habits, hemorrhoids, bloating, pain, etc.)_____
_____
__ __ Musculoskeletal concerns (arthritis, joint problems, osteoporosis, muscle pain, weakness):_____
_____
__ __ Skin (eczema, infections, rashes, etc.) _____
__ __ Psychological (mood changes, sadness_____
__ __ Neurological (numbness, tingling, balance problems, memory etc.)_____
_____
__ __ Hormonal issues (diabetes, thyroid problems, menopausal, adrenal etc.) _____
_____
__ __ Blood or lymph issues (current anemia, swollen glands etc.) _____
__ __ Allergies _____
Others:_____

Women

Onset of first menses was age_____. Periods generally last _____ days and occur every _____ days.
Date of last period _____ Bleeding is _____Heavy _____Moderate _____Light?
Do you experience PMS symptoms? _____ List:_____
Are you currently sexually active? _____ Partner(s) is/are __Male __Female
Type of birth control: _____ Are you happy with this method? _____
Are you currently experiencing any gynecological symptoms or problems? _____
_____
Any problems related to sexual function? _____
Do you have a history of sexually transmitted disease? _____ Genital warts? _____
Number of pregnancies?_____ Births?_____ Abortions?_____ Miscarriages?_____
Date of last Pap smear: _____ Abnormal Pap History? _____
Do you perform regular breast self exams? _____ Date of last mammogram, if any: _____
If menopausal or perimenopausal, list symptoms and concerns: _____

Men

Are you currently sexually active?_____ Partner(s) is/are __Male __Female
History of sexually transmitted diseases?_____ Genital warts?_____
Date of last prostate exam? _____ PSA test? _____
Trouble with urination? (frequency, hesitancy, pain, dribbling)_____
Trouble with sexual function/libido? _____ If yes, explain:_____

LIFESTYLE

Currently I am (circle one) Employed. Unemployed, Student. Vocation?: _____
How many hours do you work per week? _____ Number of play/relaxation hours? _____
What are your primary sources of stress? _____
How much do you think they impact your life? _____ Do you wear seatbelts? Y/N. Bike helmet? Y/N
What is your exercise routine? _____
What else do you do in order to manage stress/ take care of yourself?_____
Who do you support (emotional, financial etc.)? _____
Who provides you support (emotional, social, financial etc.)? _____
Do you experience any of the following? (check all that apply)

- ☐ Social isolation
- ☐ Social anxiety
- ☐ Loss of ability to care for self
- ☐ Not enough to eat
- ☐ Violence at home or in relationship
- ☐ Inadequate housing
- ☐ Suicidal thoughts
- ☐ Job insecurity
- ☐ Unsafe;how?_____

Caffeine/Amount? _____Alcohol/Amount? _____
Smoking history and amount? _____ Recreational drugs? _____

Take a minute to imagine what good health means to you. What would it look like if all the health concerns you currently have were successfully solved? What would you be able to do? How would you feel?

What specific change(s) are YOU ready to make in order for you vision of health to happen?

What, if any, barriers to this exist? How could you overcome these?

How ready do you feel to make the changes above, on a scale from 1-10?

1 2 3 4 5 6 7 8 9 10

(1=not sure, 5=depends how hard it is, 10=I'll do what it takes!)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Mountain View Natural Medicine has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact the **Office Manager @ 802-860-3366.**

I also understand that I am entitled to receive updates upon request if Mountain View Natural Medicine amends or changes its Notice of Privacy Practices in a material way.

_____ _____

Signature Relationship to Patient, if other than patient

_____ _____

Date Patient's name if not signed by patient

THIS SECTION IS TO BE COMPLETED BY Mountain View Natural Medicine IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (specify): _____

_____ _____

Name and title of employee Date

Financial Policy

PAYMENT IS EXPECTED WHEN YOU COME IN FOR AN APPOINTMENT

- Co-Payments, deductible, co-insurance and private pay fees, where applicable are due upon check out.
- Any deductible is due as soon as the amount can be determined
- You are responsible for understanding what your insurance plan will cover or not cover
- As a courtesy, we will bill non-participating insurance companies
- Postage and handling will be added to dispensary items. We will mail and require payment prior to mailing.

NOTIFY US OF ANY CHANGES IN YOUR ADDRESS AND/OR INSURANCE

- If your insurance changes, bring your new insurance card with you.
- Please contact your insurance company with insurance questions.

STATEMENTS ARE GENERATED FOR OUTSTANDING BALANCES

- If you are responsible for more than one patient account, we may offset an overpayment in one account to another account.
- We will assess a $25 service fee for any checks returned unpaid.
- If payment is not received within 21 days of the statement date your account will be considered delinquent

RETRUNED SUPPLEMENTS

- Any unopened item may be returned for a full refund within 30 days of purchase.
- Mail order items must be postmarked by 30 days of the original date of purchase. Return postage is nonrefundable.

WE USE COLLECTION AGENCIES FOR DELINQUENT ACCOUNTS

- If your account is delinquent, we may list your default with our credit reporting agency. If we incur any collection costs, these will be added to the balance you owe.

NOTIFY US TO CANCEL AN APPOINTEMNT

- If you need to cancel an appointment, please notify us 24 hours before the appointment.
- If you miss an appointment or are late in cancelling it, we may assess a $50.00 fee.
- If you frequently miss or cancel appointments, you may be discharged from the practice.

WE USE AND AUTOMATED SYSTEM FOR E-MAIL APPOINTEMNT REMINDERS

- An automated e-mail will be sent to the listed e-mail address prior to your appointment.
- A courtesy phone call made by office staff will be given 48 hours prior to an appointment.

I've read the above financial policy of Mountain View Natural Medicine and agree to its terms. I am responsible for any balance due on my account or the patient I am responsible for.

Patient Name: _____Responsibility party name: _____

Signature: _____ Date: ____/____/___