MOUNTAIN VIEW NATURAL MEDICINE

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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name:_______________________________ Preferred name: _________________ Date of Birth:_____________

Family Ethnicity:_____________________Parent(s)/Legal Guardian(s):_________________________________

Street Address:____City/State/Zip:______ ____________________

Home Phone:___________________ Work Phone:____________________ Cell Phone:___________________

Email Address:____ Maiden name:____________________

May we leave a medically related message at home? ________ at work?________ on cell?__________________

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

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, allergies, etc.)

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 abnormal and briefly 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

What is your vocation? ____

What are your primary sources of stress? ____

How much do you think they impact your life? ____

How many hours do you work per week? _______ Number of play/relaxation hours? ____________________

What do you do in order to manage stress/ take care of yourself? _____________________________________

What is your exercise routine? ____

Do you wear seatbelts? Y/N A bike helmet? Y/N

What do you do for fun? ____

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!)

MENTAL HEALTH:

Over the **last 2 weeks**, how often have you been bothered by the following problems?:

Little interest or pleasure in doing things?

Not at all	Several days	More than half the days	Nearly daily
0	1	2	3

Feeling down, depressed or hopeless?

Not at all	Several days	More than half the days	Nearly daily
0	1	2	3

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: ____/____/___