Auburn Naturopathic Medicine

PERSONAL INFORMATION

Mr/Mrs/Miss/Dr. Last Name_____ First Name: _____

Birth date:_____ Age:_____ Gender: _____

Street Address:_____ City:_____ State:_____ Zip:_____

Email Address:_____

Home Phone:_____ Cell:_____ Office:_____

Marital Status: (Circle) Minor / Single/ Married/ Widowed/ Long Term Partner

Name and address of person responsible for patient, if different from patient:

_____

Associations

Are you currently: (Circle One) Employed Retired Disabled Other:_____

Occupation:_____ Employer:_____

Primary Care Provider:_____ Contact Number:_____

How did you hear about us?_____

Name of referring patient or practioner:_____

May we contact them to thank them for referring you? YES NO

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Emergency Contacts

Name of family member to contact:_____

Relationship:_____ Phone:_____ Alt Phone:_____

Friend or relative not at the same address:_____

Relationship:_____ Phone:_____ Alt Phone:_____

How To Contact You

Some patients prefer not to have health related messages left where others might hear them. Please let us know where we may leave messages that may be sensitive and initial after you make a choice.

You MAY leave messages for me on: (circle one) Home Cell Office E-mail

Initials:_____

You MAY discuss details of my health with:_____

Initials:_____

Health Concerns

Please list your main concerns that you would like to address

1.	4.
2.	5.
3.	6.

Patient Signature: _____ Date:_____

Guardian Signature:_____ Date:_____

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Informed Consent

I, _____, acknowledge that I am accepting treatment from a Naturopathic Doctor at Auburn Naturopathic Medicine. I understand that there are intrinsic differences between the care of Naturopathic Doctors and Medical Doctors. At this time it is my decision to pursue Naturopathic treatment for any condition I have. I also understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution of any or all conditions that I may have.

_____ _____

Patient/Guardian Signature Today's Date

_____ _____

Physician/Witness Today's Date

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Client Fees and Payment Policies

As we are committed to providing economical, quality health care, full payment for all charges is required at the time of service. In special circumstances, the physician may make alternative arrangements. We accept payment by check, cash, MasterCard or Visa. Checks or credit cards that are denied for lack of funds will incur a fee of $35.00.

Cancellations

We reserve your scheduled appointment time just for you and we ask that you respect this time commitment. **We require 24 hours notice received during normal business hours for cancelled or rescheduled visits.** There is no charge for visits cancelled with 24 hours notice. There may be a percentage of cost of the scheduled visit for cancellations with less than 24 hours notice or if no notice is received.

Insurance

In order to provide you with the best possible health care, we do not directly bill insurance companies. All charges incurred at Auburn Naturopathic Medicine a are your responsibility. Many healthcare insurance companies will reimburse you for services provided if you submit the invoice from our office. It is up to you to submit the proper paperwork for reimbursement. Due to plan variances, we are unable to inform you in advance of what each policy covers. It is up to you to check with your individual plan to determine coverage.

I agree to make payments according to the policies of Auburn Naturopathic Medicine. I understand that some or all of the services I receive may not be covered or may have coverage limitations or restrictions under my health insurance plan. It is my responsibility to know what my plan covers.

Patient Signature: _____ Date:_____

Guardian Signature:_____ Date:_____

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Privacy Policy and Legal Notice

Auburn Naturopathic Medicine complies with all aspects of the federal HIPAA law, which stipulates your rights as a medical patient. At Auburn Naturopathic Medicine you have the following rights:

- All of your medical records in our possession are controlled so that only your medical provider and essential office staff are allowed to see the contents of your records.
- Your records will not be shared with anyone outside of this office except for the very rare occasions as mandated by law including a court order or in cases where the law mandates that we act to preserve life by breaking confidentiality, as in the case where we firmly believe that you might endanger the life of another or yourself.
- Clinics that contract with insurance companies are required by contract to divulge records to the insurance company as well as your social security number. Because of this we do NOT accept insurance, we will NOT share your records with outside private companies and we will only ask for your social security number if required when ordering lab work. Your social security number will NOT be saved in any form in our office.
- We believe that your medical records are YOUR records. You may request a copy of your records and we will make you a copy within 5 working days of your request. We may charge you reasonable copying fees for this service. Your "records" include anything actually in your chart, but does not include incidental notes that doctors may make for their own use, but which are never entered into the official chart notes. The HIPAA law allows doctors to refuse a request for records in extremely rare and unusual cases.
- We will not confirm or deny that you are a patient of our clinic, even to your family members, unless you give us explicit permission to do so. Your right to seek medical care with complete confidentiality is a right we take seriously.

If you have any questions or concerns about our privacy policy, or your rights as a patient in our clinic, please bring them to us at your earliest convenience.

I understand the above notice: _____ _____

Signature Today's Date

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Cancer Management

This notification is for any patient who may be consulting in this office. The law in the State of California restricts the primary treatment of patients with cancer diagnosis to only physicians who are licensed as MD or DO oncologists.

Any involvement in diagnosis, treatment or other means by healthcare providers who do not have MD or DO qualifications will be considered adjunctive or ancillary care.

I acknowledge that I have been informed of the law in the State of California regarding primary cancer treatment, and as a patient will direct my healthcare in whatever way best suits my own personal needs and desires.

_____ _____

Patient/Guardian Signature Today's Date

_____ _____

Physician/Witness Today's Date

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Your Name: _____

Thank you for taking the time to tell us a little more about your child. By filling this out before your appointment, it gives us much more time to discuss your concerns and our plan to address them.

1. What are your child's most important health issues?

A. _____
B. _____
C. _____
D. _____
E. _____

2. Does your child have any allergies to foods, drugs or other allergens in your environment (cats, mold, dust…) YES_____ or NO_____. If yes, please explain:_____
_____
_____

Please List any Major Illnesses, Injuries, Surgeries and Hospitalizations your child has had:		
Approximate Dates	Illness or Reason	Outcome

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Immunizations: Check all that apply				
✓	Vaccine	✓	Vaccine	Approximate Date/Age
	Measles		Tetnus	
	Mumps		Small Px	
	Polio		Influenza	
	DPT		Hep B	
	MMR		Other	

Conditions

Please circle: Y=your child has now N=your child never has had P=your child had in the past

_____Jaundice	_____Seizures	_____Rashes
_____Colic	_____Birth Defects	_____Allergies
_____Blue Baby	_____Cerebral Palsy	_____Other
_____Diarrhea	_____Birth Injuries	_____Fever

Feeding and Sleeping

Feeding: _____Breast Fed _____Formula _____Soy or Milk _____How long?

Age Began: _____Solid foods _____Sitting _____Crawling _____Walking

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_____First Words

Child's Sleep patterns first year:_____

Briefly describe child's typical daily diet:_____

_____

Symptoms

Please circle: Y=your child has now N=your child never has had P=your child had in the past

Heart Murmurs Y P N

Eczema Y P N

Bleeding gums Y P N

Nose Bleeds Y P N

Acne Y P N

High Fever Y P N

Chronic Rash Y P N

Hearing Loss Y P N

Diarrhea Y P N

Sore Throats Y P N

Gas Y P N

Lack of appetite Y P N

Join Pains Y P N

Hair Loss Y P N

Burn urinating Y P N

Vomiting spells Y P N

Anemia Y P N

Stomach Aches Y P N

Constipation Y P N

Headaches Y P N

Sleep Issues Y P N

Body/Breath odor Y P N

Hives Y P N

Family History

_____Heart Disease

_____Hypertension

_____Eczema

_____Diabetes

_____Arthritis

_____Cancer

_____Birth Defects

_____Tuberculosis

_____Allergies

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_____Mental Illness _____Hay Fever _____Other

# of previous pregnancies and/or miscarriages:_____

Mother's legal age at birth:_____

Mother's health during pregnancy:

_____Bleeding

_____Illness

_____Nausea

_____Thyroid problems

_____Physical or emotional trauma

_____Cigarettes, alcohol, drugs

Delivery/Term:

_____Full

_____Premature

_____Complications (Y or N)

_____Late

_____Weight at birth

_____Length of labor

_____Length

_____Head

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Medications and Supplements

Please list any and all prescription medications, over-the-counter medications, vitamins, herbs, and stimulants your child is currently taking.

On your first visit, please bring all of your child's supplement bottles with you.

Name of Product	Brand	Dose	Frequency/How Long
Ex) Vitamin C	Thorne Research	1.000 mg per day	2 years

Do you have any adverse (or opposite) reactions to medications: Y ___ N __
If so, please explain:

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