Monadnock Natural Medicine

Patient Registration Form

Patient Information

Last Name:_____ First Name:_____ MI: _____
Maiden Name:_____ Date of Birth: _____ Sex: _____
Street Address:_____
City:_____ State:_____ Zip:_____ SS#:_____
Employer/School:_____ E-mail Address:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Mother's Name (minors only): _____ Father's Name: _____
Emergency Contact: _____ Contact's Phone #:_____
Emergency Contact is my: (specify relationship) _____
How did you hear about us? *Newspaper Ad* *News Story* *Mailer/Flyer* *Website*
(Circle one) *Workshop/Event* *Medical Referral* *Friend/Family* *Yellow Pages*

Responsible Party Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Name:_____ Phone: _____
Street Address: _____
City:_____ State:_____ Zip:_____

Acknowledgement of Receipt

Monadnock Natural Medicine is required to provide you with a copy of our Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The Notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights, and explains how you may exercise those rights.

I hereby acknowledge that I have received a copy of Monadnock Natural Medicine's Notice of Privacy Practices. 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.

_____ _____
Patient's Name (PRINT) Patient's Guardian/Representative (PRINT)

_____ _____
Signature of Patient Signature of Guardian/Representative

_____ _____
Date Relationship to Patient/Representative Authority

_____
Date

Insurance Information:

Insurance Company: _____ Insurance Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
ID Number: _____ Group Number: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Patient's Relation to Subscriber: (circle one) Self Spouse Child

FOR OFFICE USE ONLY: Unable to Obtain Acknowledgement of Receipt
This section serves as a record of Monadnock Natural Medicine'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: _____

Monadnock Natural Medicine
Adult Patient Profile

Last Name: _____ First Name: _____ MI: ____
Nickname:_____ Date of Birth: _____ Age:_____ Sex: _____

Present Health Concerns

Please list your health concerns in order of priority, including date of onset and severity of symptoms.

1. _____
2. _____
3. _____
4. _____
5. _____

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			
Specialist			
Therapist			
Other			
Pharmacy			

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

Medication/Supplement	Reason	Date Began	Dose

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

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Review of Systems: Check☑ symptoms that you currently experience.

Constitutional	Heart & Circulation	Digestion & Intestine		WOMEN: Reproductive
Max Weight:_____Year_____	Heart Murmur	Bad Breath		Age Period Started_____
Min Weight_____Year_____	Irregular Heartbeat	Excessive Thirst		Length of Cycle_____
Appetite Change	Chest Pain	Difficulty Swallowing		Length of Flow_____
Weight Change	Heart Palpitations	Indigestion		Last Menstrual Period_____
Fevers OR Chills	Lightheaded	Belching		# Pregnancies:_____
Sweats	Fainting	Heartburn / Reflux		# Live Births:_____
Feel Hot OR Cold	Blood Clots	Nausea		# Miscarriages:_____
Fatigue	Deep Leg Pain on Walking	Vomiting		# Abortions:_____
Weakness	Varicose Veins	Abdominal Pain Or Cramping		Last Pap Smear: _____
EYES	Swelling of Feet / Ankles	Gas OR Bloating		Last Mammogram: _____
Eye Pain	Cold Hands/ Feet	# Bowel Movements / Day: ___		Irregular Menstrual Cycle
Poor Night Vision	Anemia	Constipation		Bleeding Between Periods
Glasses OR Contacts	Easy Bruising	Loose Stools OR Diarrhea		Heavy Periods
Near OR Far Sighted	Bleeding Tendency	Mucus In Stool		Painful Periods
Blurred OR Double Vision	Blood Transfusions	Blood In Stool		Premenstrual Syndrome
Cataracts	**Chest & Lungs**	Rectal Pain / Itching		Pelvic Pain
Dry Eyes	Shortness of Breath	Hemorrhoids		Abnormal Pap Smear
Ears, Nose, Mouth, Throat	At Rest Walking Lying Down	Hernia		Vaginal Discharge
Ringing In Ears	Wheezing OR Asthma	Jaundice		Vaginal Itching OR Soreness
Earaches	Cough: Wet OR Dry	**Muscles, Bones & Joints**		Sores on Genitals
Itchy Ears	Breast Lump OR Pain	Neck Pain		Infertility
Excessive Ear Wax	Nipple Discharge	Back Pain		Sexual Difficulties
Hearing Loss OR Hearing Aid	Self Breast Exams	Muscle Pain		Pain With Intercourse
Nosebleeds	**Neurological**	Joint Pain (Indicate R or L)		Menopausal Symptoms
Stuffy OR Runny Nose	Dizziness	Wrist	Fingers	Hormone Replacement
Postnasal Drip	Poor Balance	Elbow	Shoulder	MEN: Reproductive
Sinus Problems	Poor Coordination	Hip	Knee	Sores On Genitals
Change in Taste OR Smell	Tremors OR Shaking	Ankle	Foot	Discharge
Teeth / Gum Problems	Seizures	Joint Swelling		Testicle Lump/Swelling/Pain
Grinding Teeth	Headaches	Morning Stiffness:___Hours		Prostate Problems
Dentures	Migraines	Joint Replacements		Infertility
Mouth Sores	Numbness OR Tingling	Muscle Weakness		Sexual Difficulties
Dry Mouth	Nerve Pain	Muscle Cramps		Self Testicular Exam
Sore Throat	Memory Loss	**Skin, Hair, Nails**		**Bladder & Kidney**
Hoarseness	Poor Concentration	Acne		Waking To Urinate
Jaw Clicking OR Pain	Changes In Speech	Rashes		Loss Of Bladder Control
Facial Pain	**Mental / Emotional**	Itching OR Hives		Frequent / Urgent Urination
Immune System	Mood Swings	Dry Skin OR Eczema		Interrupted Flow
Frequent Infections	Anger, Frustration, Irritability	Moles OR Growths		Recurrent Infections
Allergies to Food	Sadness OR Anxiety	Poor Wound Healing		Painful Urination
Allergies To Environment	Phobias	Hair Loss		Blood OR Pus In Urine
Lymph Gland Swelling/Pain	Insomnia OR Disrupted Sleep	Nail Problems		Kidney Stones
Other:		Other:		

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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/annual exam: _____ Date of last blood tests: _____
Childhood Illnesses: Your health as a child was: Good Fair Poor

Chicken Pox	Mononucleosis (Mono)	Rheumatic Fever
Diphtheria	Mumps	Tonsilitis
Ear Infections	Pertussis (Whooping Cough)	Scarlet Fever
German Measles (Rubella)	Pneumonia	Strep Throat (Recurrent)
Measles	Polio	

Personal and Family Medical History:
Please check the☑ box next to each condition that applies to you or one of your biological family members.
Key: P=Paternal; M=Maternal; GF=Grandfather; GM=Grandmother

				Grandparents				Siblings and Children				
	YOU	**Mom**	**Dad**	**PGM**	**PGF**	**MGM**	**MGF**					
Current Age or Age at Death												
Alcohol / Drug Abuse												
Allergies or Hay Fever												
Alzheimer's or Dementia												
Anemia												
Anxiety / Panic Attacks												
Arthritis / Joint Disease												
Asthma												
Autoimmune Disease												
Bleeding Disorder												
Cancer (**What Type?**)												
COPD / Emphysema												
Depression / Suicide Attempt												
Diabetes												
Eczema												
Epilepsy or Seizures												
Glaucoma												
Gall Bladder Disease												
Migraines / Headaches												
Heart Attack												
High Blood Pressure												
High Cholesterol												
HIV / AIDS												
Inflammatory Bowel Disease												
Kidney Disease												
Liver Disease / Hepatitis												
Macular Degeneration												
Osteoporosis												
Schizophrenia												
Stroke												
Thyroid Disorder												
Other:												

Social History

Marital status: Single Married Divorced Widowed Significant Other

Do you have any children? *Yes* *No* Please list their age(s) _____

Living arrangement: Alone Roommate(s) Significant other Children Grandchildren

Education level: High school College Professional school Other: _____

Occupation: Student Work Homemaker Unemployed Volunteer Retired

School/Occupation(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

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?_____

Do you:

Smoke cigarettes? Yes No Quit_____How many years? _____ Packs /day?_____

Drink alcohol? Yes No Quit_____Type? _____ Drinks per week?_____

Use recreational drugs? Yes No Quit_____Which? _____ How often? _____

Drink caffeinated beverages? Yes No Type? _____ Drinks per day? _____

Exercise regularly? Yes No If no, why?_____

What exercise? _____

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

Enjoy your job? Yes No If no, why?_____

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?_____

Diet: Please describe your typical meals.

Breakfast Time:_____	**Lunch Time:_____**	**Dinner Time:_____**	**Snacks Times:_____**

Do you have any dietary restrictions? _____

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

Water: _____ oz per day Other beverages: _____

What else would you like us to know about you?

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

_____ _____

Signature of patient Date Signature of Doctor Date

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Monadnock Natural Medicine

Consent for Treatment

The naturopathic doctors at Monadnock Natural Medicine may perform, order, or prescribe any of the following procedures and therapies as necessary to properly evaluate, diagnose and treat your health concerns:

General Diagnostic Procedures: including, but not limited to, physical exams, diagnostic imaging (X-rays, ultrasound, etc.), venipuncture, pap smears and other specimen collection for diagnostic labwork.

Psychological and Lifestyle Counseling: promotion of wellness using recommendations for exercise, sleep, stress management and balancing of work and social activities.

Botanical and Homeopathic Medicines: use of therapeutic plant substances in oral and topical forms and homeopathic remedies (dilute quantities of naturally occurring plant, mineral and animal substances) in oral and topical forms.

Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements. May include intramuscular vitamin injections and intravenous nutrient therapy.

Soft Tissue and Osseous Manipulation: use of massage, neuromuscular techniques, muscle energy stretching, craniosacral therapy or visceral manipulation, and manipulations of the extremities and spine.

Prescription Items: pharmaceutical medications contained within the New Hampshire naturopathic formulary, barrier contraceptives, and immunizations.

Potential Risks: including, but not limited to, pain, discomfort, blistering, discolorations, infection, burns, fainting or tissue injury from needle insertions, topical procedures, heat or frictional therapies; adverse reactions to prescribed herbs or supplements such as allergic reaction, headache, nausea; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: including, but not limited to, restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention and management of disease.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy.

I hereby authorize the naturopathic doctors at Monadnock Natural Medicine to perform, order, or prescribe the above procedures and therapies as necessary to facilitate my diagnosis and treatment. I understand that I may ask questions regarding my individual treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic doctors at Monadnock Natural Medicine.

_____	_____
Patient's Name (PRINT)	Patient's Guardian/Representative (PRINT)
_____	_____
Signature of Patient	Signature of Guardian/Representative
_____	_____
Date	Relationship to Patient/Representative Authority
	_____
	Date

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Monadnock Natural Medicine

Protected Health Information Management

In general, the HIPPA 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)

Home Telephone ___________________________
OK to leave message with detailed information
Leave message with call-back number ONLY
OK to fax _____________________________
Work Telephone ___________________________
OK to leave message with detailed information
Leave message with call-back number ONLY

Written Communication
OK to mail to my home address
OK to mail to my work/office address

Other (email, cell phone, etc.) _________________________
____

Patient's Name (PRINT)

Patient's Guardian/Representative (PRINT)

Signature of Patient

Signature of Guardian/Representative

Date

Relationship to Patient/Representative Authority

Date of Birth

Date

FOR OFFICE USE ONLY

Healthcare entities must keep records of PHI disclosures. Individuals have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

RECORD OF DISCLOSURES

Date	Disclosed to Whom	Authorized	Purpose	By Whom Disclosed	Type	Method

Type key: E=Entire Record, P=Progress Notes, L=Lab/Imaging Reports

Monadnock Natural Medicine, PLLC

holistic health care for the whole family

Notice to all Cigna and Harvard Pilgrim insurance patients:

Naturopathic Doctors are considered to be specialists by Cigna and Harvard Pilgrim, and are therefore unable to act as a Primary Care Doctor for patients with these insurances. As a result, we are unable to submit insurance claims for Wellness Checks or for preventative appointments.

Please note: HMO insurance policies with either Cigna or Harvard Pilgrim DO NOT provide coverage for Naturopathic Services, and patients with these insurances must pay for services at the time of their appointment.

Please be aware that not all visits or procedures will be covered by insurance. Important: until we can verify your insurance coverage, payment is due in full at the time of your visit. If your insurance company denies payment for any portion of your bill for any reason, you are responsible for the cost of treatment at the current rates.

We must know PRIOR to your appointment if you wish the visit to be covered by insurance in order to allow us time To verify your coverage. Unfortunately we are unable to submit claims for previous visits. We are unable to provide information regarding type, amount, or timing of insurance reimbursements.

Patients with insurance that requires a co-insurance (a percentage of the invoice total), MUST speak to their insurance company prior to an appointment in order to understand what their individual plan details are, especially as relates to deductibles.

Payment is due in full at the time of your visit. For your convenience we accept cash (exact change appreciated), Check, Visa, Mastercard, Discover and American Express.

I have read, understand and agree to the above policies. I also agree that I have had the opportunity to discuss all fees and payment options, and understand my responsibility for payment of services rendered.

_____ _____

Patient Signature Date

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Monadnock Natural Medicine

How Do I Check My Insurance Benefits?

Patient Name _____ **Insurance ID#** _____
Insurance Company _____

Our clinic will happily bill your insurance for your visit; however, it is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximums. Please follow steps 1-6 when calling to find out benefits and eligibility.

First, Call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

1. When did my coverage begin and when is it valid thru?
Beginning Date of Coverage _____ Ending Date of Coverage _____

2. Do I need a referral from my primary care physician (PCP) for alternative services?
_____ Yes _____ No

3. What are my benefits for the following services? *
Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending on whether the doctor is In or Out-of-Network with your insurance company and whether your plan includes Out-of-Network benefits.
Naturopathic: % Covered _____ Co-pay/ Co-Insurance _____ Year Max _____

4. What is my deductible for the year and has any or all of it been met?
Deductible $ _____ Amount of Deductible met so far $ _____ Date _____

5. What was thename of the representative I spoke with: _____ Date_____

* Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance. Thanks so much!

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