NEW PATIENT INTAKE FORM

Patient Name: Date of Birth: Today's Date:

Age: Female ❒ Male ❒ Last 4 of SS# E-mail:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Okay to Leave Detailed Messages at: Home ❒ Work ❒ On my Cell ❒

Emergency Contact Name & Phone Number:

Single ❒ Married ❒ Separated ❒ Other ❒

Occupation: Religious Affiliation (Optional):

Hobbies:

Primary Care Physician: Okay to contact: Yes ❒ No ❒

Referred by:

HEALTH INSURANCE INFORMATION

Primary Insurance: Naturopathic Coverage?

Policy Holder's Name: Policy Holder's Date of Birth:

Policy Holder's Employer: Co-payment for Office Visits:

OFFICE POLICIES

PAYMENT POLICY: 100% of all doctor visits, other treatments, and supplements fees are due at the time of services. We accept cash, checks, debit and credit cards as payment. All sales are final. We cannot provide refunds or exchanges. We charge $25.00 for any returned check. If you have insurance coverage for Naturopathic care, we are happy to bill your primary insurance for you.

CANCELATION POLICY: Last minute cancellations of scheduled appointments are challenging to fill, wasteful of an opportunity for another patient, and costly for the clinic. **We therefore require changes or cancellations to be made at least 24 hours prior to your scheduled appointment.** Otherwise, you will be charged $35.00 for the 1st missed visit, and $100.00 for any subsequent missed visits.

I, the patient, understand that I am financially responsible for all charges regardless of insurance coverage and/or treatment outcome. I understand that 100% of fees are due at the time service is rendered, and that all sales are final. I authorize Baker Family Naturopathic to bill my health insurance for services rendered. I understand that I will be charged for any appointment missed or cancelled less than 24 hours in advance. I hereby agree to pay any and all charges.

Signature: Date:

Relationship to the Patient:

PATIENT HEALTH HISTORY Patient Name:

Allergies to Medications:

Current Medications:

Current Supplements:

Most Important Health Concerns:

Reason for Today's Visit:

FAMILY HISTORY

Disease	*Yes*	*No*	*Which Relative(s)*	*Deceased/Living*
Breast Cancer	Y ❒	N ❒		
Other Cancer	Y ❒	N ❒		
Diabetes	Y ❒	N ❒		
High Blood Pressure	Y ❒	N ❒		
Heart Disease/Stroke	Y ❒	N ❒		
Kidney Disease	Y ❒	N ❒		
Liver Disease	Y ❒	N ❒		
Blood Disorder	Y ❒	N ❒		
Mental Illness	Y ❒	N ❒		
Alcoholism/Drug Abuse	Y ❒	N ❒		
Thyroid Issues	Y ❒	N ❒		
Cataracts/Glaucoma	Y ❒	N ❒		
Osteoporosis	Y ❒	N ❒		
Other:				

PERSONAL HISTORY:

Major Illnesses (type & when):

Surgeries/Hospitalizations/Accidents (type & date):

Major Toxic Exposure: pesticides/chemicals Heavy Metals

Have *YOU* Ever Experienced: Check for yes or no. ***Please underline which condition***

Y	N	Condition	Y	N	Condition
Y ❒	N ❒	Measles/Mumps/Rubella/Chicken Pox/Mono/Strep	Y ❒	N ❒	Headaches/Numbness/Sensory Change/Head Injury
Y ❒	N ❒	Liver Disease/Hepatitis/Jaundice	Y ❒	N ❒	Epilepsy/Loss of Consciousness
Y ❒	N ❒	Gallbladder Disease/Gallbladder Stones	Y ❒	N ❒	Fatigue/Insomnia/Waking Not Rested
Y ❒	N ❒	Kidney Disease/Urinary Problems/Bladder Infections	Y ❒	N ❒	Poor Memory/Confusion/Foggy Mind
Y ❒	N ❒	Gonorrhea/Chlamydia/Herpes/ Genital Warts/Other Sexually Transmitted Disease	Y ❒	N ❒	Anemia/Nose Bleeds/Easy Bruising
Y ❒	N ❒	Pain/Impotence/Problems with Sexual Intercourse	Y ❒	N ❒	Hot Flashes/Night Sweats
Y ❒	N ❒	Ovarian/Uterine/Testicular Pain, Problems, or Masses	Y ❒	N ❒	Thyroid/Pituitary/Adrenal Problems
Y ❒	N ❒	Lung Disease/Shortness of Breath/Asthma/Tuberculosis	Y ❒	N ❒	Weight Loss/Gain (>10 Lbs.)

Patient Name: ______________________________

Y ❐	N ❐	Racing Heart/Chest Pain/High Cholesterol/Hypertension	Y ❐	N ❐	Sinus Problems/Runny Nose/Allergies
Y ❐	N ❐	Muscle Cramps/Tightness/Aches	Y ❐	N ❐	Recurrent Colds/Flues/Infections
Y ❐	N ❐	Visual Changes/Eye Pain Infections/Cataracts	Y ❐	N ❐	Cancer/Pre-Cancer of Any Kind
Y ❐	N ❐	Ear Pain/Ear Infections/Decreased Hearing/Ringing	Y ❐	N ❐	Skip Meals/Dieting/Binge Eating
Y ❐	N ❐	Joint Pain/Arthritis/Bone Loss/Bone Pain	Y ❐	N ❐	Diabetes/Hypoglycemia/Sugar Craving
Y ❐	N ❐	Digestive Troubles/Pain/Gas/ Bloating/Constipation/Diarrhea	Y ❐	N ❐	Depression/Anxiety/Irritability/ Weepiness
Y ❐	N ❐	Itching/Rashes/Eczema/Psoriasis/ Mole Changes	Y ❐	N ❐	Dry Skin/Excessive Sweating/ Hair loss

Other Health Problems/Concerns: ______________________________

____

SOCIAL HISTORY:

Exercise # of days/week:________________type(s):______________________________

Caffeine (# cups/day): Coffee_________Tea____________Soft Drinks______________________________

Tobacco Use: Y ❐ N ❐ In the past ❐ # of cigarettes/day:______ total years smoking:_____________

Alcohol Use: Y ❐ N ❐ In the past ❐ # of drinks_________ per day ❐ week ❐ month ❐

Drug Use: Y ❐ N ❐ In the past ❐ Type(s):______________________________

Use: daily ❐ weekly ❐ monthly ❐ almost never ❐

Sexually Active: Y ❐ N ❐ Prefer: Men ❐ Women ❐ Both ❐ Practice Safe Sex? Y ❐ N ❐

History of Sexual/Physical/Emotional Abuse: Y ❐ N❐______________________________

Currently Live With:______________________________

OB/GYN HISTORY (*Women Only*):

Age at 1st menses:____________ First day of Last Period:_________________________ Periods Regular: Y ❐ N ❐

Currently pregnant: Yes ❐ No ❐ Maybe ❐ Are you trying to get pregnant: Y ❐ N ❐

Birth Control Method:______________________________ Are you satisfied with this method: Y ❐ N ❐

Last Annual Exam:______________________________ Abnormal Pap Smear Ever: Y ❐ N ❐

Total Number of Pregnancies:___________ # Births:____________ # Miscarriages:___________ # Abortions:___________

Number of Children Breast Fed:____________ Total # Years on Hormones (including birth control):_________________

Last Mammogram:______________ Abnormal Mammogram Ever: Y ❐ N ❐______________________________

Gyn and/or Breast Surgeries & Dates:______________________________

Question/Concerns:______________________________

I look forward to assisting you with your health!

INFORMED CONSENT TO TREATMENT

Patient's Name:____

This is to acknowledge that I have been informed and understand that:

1. As a Naturopathic Physician, Dr. Emma Baker does not have hospital privileges and can only prescribe certain drugs. Therefore, I, the patient, will maintain an on-going relationship with a local primary care M.D. or D.O. physician of my choosing.
2. **In the case of a medical emergency, I, the patient, am to call 911 or proceed to the nearest emergency room.**
3. I, the patient, understand that Dr. Emma Baker offers **adjunctive care only to cancer patients**, and I will therefore maintain care with an M.D. or D.O. oncologist of my choosing should I be diagnosed with cancer.
4. Any treatment or advice provided to me as a patient of Dr. Emma Baker N.D. is not mutually exclusive from any other treatment or advice that I maybe receiving now or in the future from another healthcare provider.
5. I, the patient, am at liberty to seek or continue medical care from any physician, surgeon, or other healthcare provider.
6. The treatment and therapies provided or recommended by this health center may be different than those usually offered by other licensed healthcare providers.
7. There have not been any representations made regarding the likelihood of success of any recommendation(s) or treatment(s) offered.
8. I understand that I am responsible for all fees regardless of insurance coverage and/or treatment outcome. I further understand that 100% of these fees are due at the time service is rendered.

I hereby authorize and consent to treatment.

____ ____________________

Signature of Patient/Guarantor (if patient is a minor) Date

____ ____________________

Signature of Witness Date

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: ____________________ Initials: ____________________

Reason: ______________________________