



# Patient Registration Form

## Center for Holistic Medicine

### PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-Mail: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Male/ Female Married: Y N

Race: \_\_\_\_\_ Ethnicity:  Hispanic  Non-Hispanic  Decline Language: \_\_\_\_\_

Occupation: \_\_\_\_\_ Student Status: Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_

Children \_\_\_\_\_ Work Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-Mail: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Occupation: \_\_\_\_\_ Relationship to patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Partner \_\_\_\_\_ Dependent \_\_\_\_\_

Employer: \_\_\_\_\_ Work Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Insured Name	Date of Birth	Insured Name	Date of Birth
Policy I.D. #	Group #:	Policy I.D. #:	Group #

### OTHER INFORMATION

Illness/Injury is job related: \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, Date of Injury: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Contact: \_\_\_\_\_

Employer Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How did you hear about our office: \_\_\_\_ Yellow Pages \_\_\_\_ Personal Reference (Name): \_\_\_\_\_ Other: \_\_\_\_\_

Illness/Injury related to an accident?: \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, Date of Accident: \_\_\_\_\_

Do you have an attorney? \_\_\_\_\_ Yes \_\_\_\_\_ No

Attorney Name: \_\_\_\_\_

Attorney Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### IN CASE OF EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT.  
I UNDERSTAND THAT REGARDLESS OF INSURANCE COVERAGE, I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES PERFORMED.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_  
DATE

## HEALTH HISTORY

**Patient Name** \_\_\_\_\_

**Birthdate** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To help us meet all your healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date _____ Place of birth _____ Highest level in school _____ Occupation _____ Marital status _____ Hobbies _____ Exercise/recreation _____ Habits: Smoking (type & amount/day) _____ If former smoker, date quit _____ Alcohol (type & amount/day) _____ Caffeine (type & amount/day) _____ Street drugs (type & amount/day) _____ Usual weight _____ Date of last dental exam _____ Please list all allergies (foods, drugs, environment) _____ _____	When was your last physical exam? _____ Name of doctor _____ Phone _____ Please list all serious illnesses, operations, and other hospitalizations you have Experienced and Indicate years these occurred: <input type="checkbox"/> none _____ _____ Please list all medicines you are currently taking (include nonprescription drugs): <input type="checkbox"/> none _____ _____ Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): <input type="checkbox"/> none _____ _____ _____ _____
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**Chief Complaints**

**Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:**

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History**

**Have you ever had the following: (Circle 'yes' or 'no', leave blank if uncertain)**

Measles.....No	Yes	Migraine headaches.....No	Yes	Hives or Eczema.....No	Yes
Mumps.....No	Yes	Tuberculosis.....No	Yes	AIDS or HIV+.....No	Yes
Chickenpox.....No	Yes	Diabetes.....No	Yes	Infectious Mono.....No	Yes
Whooping Cough.....No	Yes	Cancer.....No	Yes	Bronchitis.....No	Yes
Scarlet Fever.....No	Yes	Polio.....No	Yes	Mitral Valve Prolapse.....No	Yes
Diphtheria.....No	Yes	Glaucoma.....No	Yes	Stroke.....No	Yes
Smallpox.....No	Yes	Hernia.....No	Yes	Hepatitis.....No	Yes
Pneumonia.....No	Yes	Blood or Plasma Transfusions.....No	Yes	Ulcer.....No	Yes
Rheumatic Fever.....No	Yes	Back Trouble.....No	Yes	Kidney Disease.....No	Yes
Arthritis.....No	Yes	High or Low Blood Pressure.....No	Yes	Thyroid Disease.....No	Yes
Venereal Disease.....No	Yes	Hemorrhoids.....No	Yes	Bleeding Tendency.....No	Yes
Anemia.....No	Yes	Date of last Chest X-Ray:_____		Any other disease (please list)	
Bladder Infections.....No	Yes	Asthma.....No	Yes	_____	
Epilepsy.....No	Yes			_____	

**Family History**

**Has any blood relative had any of the following: (Circle 'yes' or 'no', leave blank if uncertain)**

Relationship		Relationship	
Cancer.....No	Yes _____	Stroke.....No	Yes _____
Tuberculosis.....No	Yes _____	Epilepsy.....No	Yes _____
Diabetes.....No	Yes _____	Allergies.....No	Yes _____
Heart Disease.....No	Yes _____	Anemia.....No	Yes _____
High Blood Pressure.....No	Yes _____	Bleeding Tendency.....No	Yes _____
Asthma.....No	Yes _____	Chronic Lung Disease.....No	Yes _____
Drug or Alcohol Problem.....No	Yes _____	Mental Illness.....No	Yes _____
Leukemia.....No	Yes _____	Migraine Headaches.....No	Yes _____
Obesity.....No	Yes _____	Thyroid Disease.....No	Yes _____
Ulcer.....No	Yes _____	Depression.....No	Yes _____
High Cholesterol.....No	Yes _____	Kidney Disease.....No	Yes _____
Glaucoma.....No	Yes _____	Gout.....No	Yes _____

**Do you have now or have you had within the past year: (Circle 'yes' or 'no', leave blank if uncertain)**

Weakness or paralysis.....No	Yes _____	Shortness of breath.....No	Yes _____	Joint pain or stiffness.....No	Yes _____
Tire easily or weakness.....No	Yes _____	Bloody sputum.....No	Yes _____	Swollen joints.....No	Yes _____
Recent weight changes.....No	Yes _____	Wheezing.....No	Yes _____	Muscle cramps or spasm.....No	Yes _____
Change in appetite.....No	Yes _____	Chest pain or discomfort.....No	Yes _____	Sleeplessness.....No	Yes _____
Sensitivity to cold or heat.....No	Yes _____	Purple fingers or lips.....No	Yes _____	Seizures.....No	Yes _____
Persistent fever.....No	Yes _____	Swelling of hands, feet or ankles.....No	Yes _____	Depression.....No	Yes _____
Night sweats or hot flashes.....No	Yes _____	Difficulty breathing.....No	Yes _____	Memory loss.....No	Yes _____
Skin rash.....No	Yes _____	Palpitations or fluttering of the heart.....No	Yes _____	Poor coordination.....No	Yes _____
Skin trouble or changes.....No	Yes _____	Leg cramps on walking or at night.....No	Yes _____	Dizziness or fainting spells.....No	Yes _____
Change in nails or hair.....No	Yes _____	Enlarged veins.....No	Yes _____	A living will or advance directive.....No	Yes _____
Headaches.....No	Yes _____	Difficulty swallowing.....No	Yes _____	<b>Men only:</b>	
Easy bleeding or bruising.....No	Yes _____	Heartburn.....No	Yes _____	Discharge from penis.....No	Yes _____
Double vision.....No	Yes _____	Frequent belching.....No	Yes _____	Pain or lump in testicles.....No	Yes _____
Blurred vision.....No	Yes _____	Abdominal cramping.....No	Yes _____	Impotence.....No	Yes _____
Eye pain.....No	Yes _____	Nausea.....No	Yes _____	<b>Women only:</b>	
Infected eyes.....No	Yes _____	Vomiting.....No	Yes _____	Age period began: _____	
Do you wear glasses or contacts...No	Yes _____	Vomited or coughed up blood.....No	Yes _____	How many days do periods last: _____	
When was your last eye exam: _____		Chronic diarrhea.....No	Yes _____	How many days between periods: _____	
Ring in ears.....No	Yes _____	Chronic constipation.....No	Yes _____	Is the flow heavy.....No	Yes _____
Discharge from ears.....No	Yes _____	Rectal bleeding.....No	Yes _____	Do you bleed or spot between periods...No	Yes _____
Ear pain.....No	Yes _____	Black tarry stools.....No	Yes _____	Do you have pain or cramps.....No	Yes _____
Decrease in hearing.....No	Yes _____	Dark urine.....No	Yes _____	Do you have pain or cramps.....No	Yes _____
Frequent nosebleeds.....No	Yes _____	Yellow jaundice.....No	Yes _____	Date of last period: _____	
Frequent colds.....No	Yes _____	Frequent urination (day).....No	Yes _____	Date of last pelvic exam: _____	
Sinus trouble.....No	Yes _____	Frequent urination (night).....No	Yes _____	Ate of last mammogram: _____	
Loss of smell.....No	Yes _____	Increase in thirst.....No	Yes _____	Any itching in vaginal area.....No	Yes _____
Persistent hoarseness.....No	Yes _____	Painful urination.....No	Yes _____	Pain with intercourse.....No	Yes _____
Sore throat.....No	Yes _____	Leakage of urine.....No	Yes _____	Type of birth control used: _____	
Sore tongue or gums.....No	Yes _____	Difficulty in starting urine.....No	Yes _____	Currently pregnant.....No	Yes _____
Lump or discharge from breast...No	Yes _____	Blood in urine.....No	Yes _____	Number of pregnancies _____	
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks).....No	Yes _____	Lack of sex drive.....No	Yes _____	Number of full term births _____	
		Hemorrhoids.....No	Yes _____	Number of preterm births _____	
		Backaches.....No	Yes _____		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X \_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

Physician's Signature \_\_\_\_\_

Center for



H o l i s t i c  
M e d i c i n e

### CONSENT TO TREATMENT

I acknowledge that I have requested healthcare services. The doctors and practitioners of the Center for Holistic Medicine are authorized to perform any healthcare service deemed necessary. Many of the therapies offered at the center are considered unconventional and may be deemed “unproven” by the Food and Drug Administration. I understand that there is no obligation to accept or complete any therapeutic recommendations.

### ASSIGNMENT OF BENEFITS

I hereby assign all benefit payments for services rendered under the terms of my insurance policy to be paid to the Center for Holistic Medicine.

### PRIVACY POLICY

*With patient consent, Center for Holistic Medicine may use and disclose protected health information to carry out treatment, payment, and healthcare operations only. Please turn now to the end of this new patient packet. Take a few minutes to read Privacy Practices Notice and understand your rights and our responsibilities. Then please sign that form and keep the second copy for yourself.*

I have read and signed the Center for Holistic Medicine’s Privacy Practices Notice and I hereby consent to the following (*please initial where you consent to the following*):

\_\_\_\_\_ The Center for Holistic Medicine may **call my home, cell, work, or other (please circle your choice/s)** designated number and leave a message, recorded or with a person, regarding items that assist the practice in carrying out treatment, payment, and operations.

\_\_\_\_\_ The Center for Holistic Medicine may **mail to my home** or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

\_\_\_\_\_ The Center for Holistic Medicine may **e-mail to my home** or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

I have read the Center for Holistic Medicine Consent to Treatment, Assignment of Benefits, and Privacy Policy and thoroughly acknowledge, understand and agree to all of the above information.

Patient Name \_\_\_\_\_ Relationship to Patient (if minor) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# OUR FINANCIAL POLICY

*Thank you for choosing the Center for Holistic Medicine as your health care center. We are committed to your successful treatment. Please understand that full payment of your account is considered part of your treatment. The following is provided to help us serve you better by avoiding misunderstandings concerning payment for professional services.*

Center for



Holistic  
Medicine

**Forms of Payment** We accept cash, personal checks, Visa, MasterCard, and Discover.

**Regarding Insurance** It is your responsibility to find out what health services your insurance benefits will cover. Taking charge of this and educating yourself is part of your healing process.

**“In-Network” Plans.** The Center for Holistic Medicine is “In-Network” with Blue Cross/Blue Shield PPO plans. All other plans are “out-of-network”. Certain practitioners may be “In-Network” on by additional policies such as Aetna or United Health Care, please ask the office staff about this. **All co-payments and non-covered services are due at the time of service.** You are responsible for payment of all services your insurance company may deny.

**“Out-of-Network” Plans.** We require **full payment at the time of services.** We can submit the claims for you. You will be reimbursed by your insurance company.

**HMO Plans.** We **do not accept** any HMO insurance policies.

It is your responsibility to understand your benefits and the reimbursement policies of your insurance company. **We do not verify insurance benefits.** It is vital that you provide us with correct and current insurance information so that your claims may be filed properly. **All charges become your responsibility 90 days after insurance claims have been submitted.**

**Non-Covered Services.** Please be aware that some or all of the services provided may be non-covered services and not considered “reasonable and necessary” under the Medicare Program or other medical insurance. It is important, therefore, that you find out what services your health insurance will pay for prior to treatment.

**Missed Appointment.** Our policy is to charge for missed appointments **unless cancelled at least 24 hours in advance.** You will be billed for the cost of a normal office visit of your health care practitioner.

**Late Fees.** It is important for you to pay for your treatment in a timely manner. We send out monthly statement letting you know your balance due. Each statement has a “statement date” on it. If payment is not received within one month of the statement date, you will be charged the balance due plus a \$10 late fee. If you require payment arrangements, you must contact the office within one month of the first statement date to avoid a late fee. The following month you will then receive another statement with your most recent balance due including the late fee and any new charges. Again, if payment is not received within one month of the statement date, another \$10 late fee added to your balance due. After 90 days (3 months) the balance due will be charged to your credit card.

If you do not make payment arrangements with the office staff for a large outstanding balance due past within 120 days (four months), you will be referred to a collections agency and will be charged a \$25 collections fee. Other financial charges include a \$35 returned check fee. Patients whose accounts are not in good standing will be asked to pay their balance prior to receiving additional services.

I have read, understand, and agree to this Financial Policy.

Patient Name \_\_\_\_\_ Relationship to Patient (if minor) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Patient Care Payment Agreement

I agree to the following:

*For charges billed to insurance*

- CHM will charge the credit card below for services not reimbursed by my insurance company after 90 days.
- CHM will collect my outstanding balances including co-pays, co-insurance, deductible and non-covered services on the credit card below.
- CHM will refund any over payment to the credit card below.

*For charges not billed to insurance*

- If I cancel an appointment with less than 24 hour notice, CHM will collect the normal office visit fee on my credit card below.
- If I make a payment by check that has insufficient funds, CHM will collect the non-payment, plus \$35.00 returned check fee, on the credit card below.

If the card number provided is invalid or does not accept charges, I understand that I may be subject to late fees and further collections.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*Please provide your credit card information below:*

NAME ON CARD: \_\_\_\_\_

3 DIGIT SECURITY CODE: \_\_\_\_\_

MASTERCARD      VISA      DISCOVER

CARD NUMBER \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_