

VERMONT INTEGRATIVE MEDICINE
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www.vermontintegratiemedicine.com

Welcome! We look forward to providing for your health care needs and encourage your questions and participation.

Name _____ Birth date _____ Age _____

Partner/Spouse (or Parents/Guardians if under 18) _____

Address _____ City/State _____ Zip _____

Home phone _____ Work _____ Cell _____

Email address _____

Occupation _____ Employer _____

Patient Soc. Sec. # _____ How did you hear about us? _____

Name of Insurance holder & relation to patient _____ D.O.B. _____

Insurance holder employer & work phone _____

Insurance Carrier, Address, & Phone _____

I.D.# _____ Group # _____

Nearest relative not living with you & phone _____

Payment in full is expected at the time of service. (We do accept MasterCard and VISA.) The responsibility for making sure that we have all information necessary for submitting claims to any insurance company (including a copy of your insurance card, both front and back) is yours, but we are happy to assist whenever possible.

We require ***at least 72 hours notice*** in advance of missed appointments or will charge a \$65 fee. (A telephone message is sufficient. This allows us the time needed to contact others who are waiting to be seen. Note: to cancel a Monday appointment, please contact us on the Wednesday prior to your appointment.) We also charge \$5 for each returned check.

I have read the above payment policy and agree to abide by it for all services received.

Signature _____ Date _____
(parent if patient is a minor)

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Please list the reason for your visit today and your primary health concerns:

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

HEALTH HABITS

Hobbies: _____

Exercise: (what kind/s, how long and how often) _____

Sleep: Light / Sound / Insomnia How many hours of sleep? _____ Stress: High / Average / Low

Major Causes of Stress: _____

Alcohol: Y/N If yes, how much & how often? _____ form/s? _____ ever quit? Y/N If so, for how long? _____

Tobacco: Y/N If yes, how much & for how long? _____ form/s? _____ ever quit? Y/N If yes, for how long? _____

DIET (Please circle from the list below)

Junk Food / Standard American (meat, potatoes, dessert) / Wholesome / Raw / Vegetarian / Other

(describe) _____

Caffeine: Amount per day/week/month _____ Sweets/Sugars: _____ (day/week)

Red Meat: _____ (day or week) Chicken/Fish: _____ (day/week)

Fresh Fruit: _____ (day) _____ (week) Fresh Vegetables: _____ (day) _____ (week) Water: _____ (cups/day)

Vitamins, minerals, and other supplements: _____

Please list all medications you currently use, with dose and frequency, including non-prescription medicines like aspirin, antacids, etc. _____

MEDICAL HISTORY

Major illnesses & Surgeries (w/dates) _____

Date of last physical _____ last dental check-up _____ last pap smear or prostate exam _____

Last medical care received, for what & where _____

CONDITIONS (Please mark "N" if you have this now, "P" for past problems, with details & dates.)

- | | | |
|-----------------------------|----------------------------|-------------------------------|
| Allergies | Headaches | Nervous breakdown |
| Arthritis | Migraines | Pneumonia |
| Asthma | Heart problems | Reproductive problems |
| Blood Pressure, high or low | Hepatitis | Seizures |
| Bones, Broken/Fractured | Hernia | Sexually Transmitted Diseases |
| Cancer | Herpes | Stroke |
| Colds, frequent | Hypertension | Thyroid problems |
| Diabetes | Hypoglycemia | Trauma, major |
| Digestive problems | Kidney problems | Tuberculosis |
| Ear infections | Liver disease | Ulcers |
| Eczema | Muscles, Sprained/Strained | Urinary Tract infection |
| Emphysema | | |

FAMILY MEDICAL HISTORY Please provide the age/s & health conditions (or cause of death) of your family members.

Father _____ his parents _____

Mother _____ her parents _____

Sister/s _____

Brother/s _____

What diseases run in the family? _____

Terms and Conditions of Treatment

Consent for Treatment:

I understand that my care as a patient at Vermont Integrative Medicine is directed by Naturopathic Physicians, licensed acupuncturists, and/or other licensed professionals. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care.

I may be contacted by Vermont Integrative Medicine physicians for voluntary participation in clinical research projects. I do, however, have the right to refuse these programs without jeopardizing my future care at Vermont Integrative Medicine in any way.

I have fully read and understand the above agreements and authorizations.

Patient (18 years or older)

Date

Parent, Guardian, Responsible Party

Date

Insurance billing: If I am billing insurance for services rendered, I understand and agree to the following:

I authorize Vermont Integrative Medicine to release pertinent medical records related to billing directly to my insurance carrier. This release applies to support of the insurance billing process only.

I am responsible for any and all charges that my insurance company will not cover.

Vermont Integrative Medicine will courtesy bill my insurance company directly; however, I understand that I am responsible for all fees incurred that are not paid by the insurance company. Any balance remaining after receipt of insurance payment is my responsibility and due upon notification.

Signature: _____

Printed Name: _____

Date:

Vermont Integrative Medicine

Notice of Privacy Practices

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), we hereby acknowledge that to the best of our ability your privacy rights will be protected. This policy is effective January 1, 2008.

The sharing of any of your medical information or history occurs with your express and written consent only.

You may direct any concerns regarding your privacy directly with the doctor of the office manager.

Signature: _____

Printed Name: _____

Date: