Namaste Health Care

Bridget P. Early, M.D. Kate Branham, F.N.P.

New Patient Registration, Age 14 and Under

Date:_____

Patient Name	Date of Birth	Age	Sex ☐ M F	Social Security #

Race ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ White ☐ Other (specify) _____
☐ Asian ☐ Black or African American ☐ Hispanic

Language preference ☐ English ☐ Spanish ☐ Other (please specify)_____

Father's Name	Father's Mailing Address	Work Phone (Father)	Cell Phone (Father)

Father's City	State	Zip Code	Home Phone (Father)

Email Address (Father)	Employer (Father)

Mother's Name	Mother's Mailing Address	Work Phone (Mother)	Cell Phone (Mother)

Mother's City	State	Zip Code	Home Phone (Mother

Email Address (Mother)	Employer (Mother)

What is patient being seen for here today?

Who is responsible for payment of patient's medical bill? (give a name, please, not just "mom")

Insurance Information (please be sure we have a copy of any insurance cards)

If we have a copy of your card, fill out info on INSURED only. CO-PAYMENTS MUST BE PAID AT TIME OF VISIT.

IF NO INSURANCE (SELF-PAY), CHECK HERE ☐

PRIMARY INSURANCE

Primary Insurance Company	Co-pay amount	Group Name or #	ID #

Insurance Company Claims Address	Managed Plan?

City	State	Zip Code	Telephone

Insured's Name	Insured's Social Security Number	Insured's Date of Birth

Insured's Address	Insured's Relationship to Patient

Insured's City	State	Zip Code	Telephone

Insured's Employer	

SECONDARY INSURANCE

Secondary Insurance Company	Co-pay amount	Group Name or #	ID #
Insurance Company Claims Address			Managed Plan?
City	State	Zip Code	Telephone
Insured's Name	Insured's Social Security Number		Insured's Date of Birth
Insured's Address			Insured's Relationship to Patient
Insured's City	State	Zip Code	Telephone
Insured's Employer			Insured's Employer Phone

PHARMACY INSURANCE (Please make sure we have a copy of any pharmacy insurance card)

Insurance Company	Phone Number	Address

Emergency Contact for Patient (Please enter information for custodial Stepparent, if any)			
Name		Their Relationship to Patient	Home Phone
Address	City	State, Zip Code	Cell Phone
Employer (for custodial stepparent)		Work Phone	Email

Pharmacy	
Pharmacy Name	Address
Pharmacy Phone Number	Fax

How did you hear of our practice?

□ Referral (from whom?_____)

□ Another patient

□ Advertisement (where? _____)

□ Sign out front

□ Other _____

Thanks for choosing Namaste Health Care. We're glad you are here!

Namaste Health Care

Agreement for Release of Private Health Information

I, _____, understand that as part of my health care, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care; and as such, a copy of my provider's note(s) and/or other information will be sent to other professionals to whom I may be referred for diagnosis or treatment
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I fully understand and accept / decline *(please circle the appropriate choice)* the terms of this consent.

_____ _____

Signature Date

Please list persons (spouse, parent, partner, etc) who are allowed access to your medical records; indicate what kind of access by adding the appropriate number(s) after their name(s).

_____
_____
_____

1. Discuss appointment/scheduling
2. Discuss my bill
3. Discuss my lab results/diagnoses/treatment

Where can we leave telephone messages? Please check all that apply.

□ On my cell phone voicemail (number_____)
□ On my home phone answering machine (number_____)
□ On my home phone voicemail (number_____)
□ On my work phone voicemail (number_____)
□ Via my email (address_____) *Supplying your email address signifies your acceptance of the terms of use for our Patient Portal, a secure Internet-based communication system.*

Namaste Health Care

Patient's Rights and Responsibilities

Our Hours: Monday – Friday 8:30 A.M. - 5:00 P.M.
Closed for lunch 12:30 – 1:30 P.M.

Our Staff

Family Physician Practitioner – Bridget Early, M.D.
Family Nurse Practitioner – Kate Branham, R.N., F.N.P.
Licensed Practical Nurse – Heather Wren
Clinical and Office Support – Tammi Ritta
Office Support and Reception — Dawn Holzhauser
Medical Assistant (preauthorizations, precertifications, referral scheduling) – Maxine Lawson
Business Manager/Billing – Theresa Early

OUR OFFICE POLICIES

1. Dr. Bridget Early/Namaste Health Care has a professional and legal obligation to preserve the confidentiality of patient information. As a professional health care facility collecting personal information, Dr. Bridget Early/Namaste Health Care ensures that such information is treated in a confidential manner to protect the patient's right to privacy.

2. If you need a well child checkup or a routine, yearly examination, sports or school physical, please schedule an appointment at least 1 (ONE) month before it is due, leaving more immediate openings in the schedule for those with more immediate needs.

3. As a courtesy to other patients, if you cannot make your appointment or if you are going to be more than 15 (fifteen) minutes late, please call the office to cancel and/or reschedule. Failure to do so more than once may result in a NO SHOW charge, payment for which you will be responsible.

4. IF YOU NEED YOUR PRESCRIPTION REFILLED, CALL THREE DAYS (OR MORE) **BEFORE** YOU RUN OUT OF MEDICINE. Often, an office visit is necessary prior to a refill. We often cannot find time on a busy clinic day to pull and review your chart, look up your dosage and allergies and be sure the medicine doesn't interact unfavorably with any new medicines, make out the prescription and get it to the pharmacy on the same day you call. Please, please plan ahead.

5. If you need medical advice, you need to see your practitioner. Schedule an appointment through the front desk. You can leave a message for your practitioner.

6. Call your insurance company yourself and find out what and how they pay. Find out what your financial responsibilities are. Make sure your insurance company will cover lab fees. Otherwise, you may be asked to pay for the lab up front or to go to the lab your insurance company will cover.

7. Please pay your co-pay or percentage, if applicable, before you see the practitioner. **Co-pays must be paid at each visit.** Sorry, no exceptions. Cash patients, please pay on the date of service.

8. Cash patients must pay the lab fees before we will submit labs (blood work, urinalysis, and so on) for processing. Otherwise, we can supply the lab address and the patient can deal with the lab directly.

9. Patients with extensive past due balances will no longer be scheduled for appointments.

10. A Release of Information form must be filled out, signed, and dated by the guardian/patient and physician before information can be released, with the exception of immunization records. **We can only release information for which we have your signed consent to release.**

_____ _____

Patient/Legal Guardian Signature **Date**

Patient Health History

Today's Date: _____

Full Name	Birth Date	Age today	Sex □ M □ F

1. Why is patient here today?

2. What are patient's current complaints or symptoms? Be specific.

What parts of the body are affected?

How long has patient had this problem or these symptoms?

3. Current Medications. Please list all medicines the patient takes. Include: inhalers, nebulizers, prescriptions, over-the-counter, vitamins, natural medications and herbs

Medication	Dose	How often?	Who Prescribed?

If the patient takes additional medications that don't fit here, please write them on the back of this form.

4. Medical History

Describe any past injuries or significant medical condition(s) for which the patient has been treated or is currently being treated.

Patient's Birth Weight	Where was baby born?	How was (is) baby fed? □ Breastfed □ Bottle

Did patient's mother have any problems during pregnancy, labor, or delivery?

What immunizations has patient had, and when? (Answer this by giving a copy of any immunization records if available.) Continue list on back of page if necessary.

Has patient ever had any reaction to immunizations? □Yes □No

Which one(s)? What reaction(s)?

5. Allergies to any medications, foods, dyes, latex, etc.

Allergic or sensitive to	How does patient react to it?

6. For Females Only

Date last period began?	Concerns about bleeding? □Yes □No	Recent changes in periods? □Yes □No
Last day of last period?	Are patient's menstrual cycles □regular and predictable □ variable in length	Date of last Pap test?
Age at time of first period?	Has patient ever had an abnormal Pap test? □Yes □No If yes, when?	
What is patient's method of birth control?		
Has the patient ever tested positive for HPV (human papilloma virus)? □Yes □No		
Any concerns about sexual intimacy? □Yes □No		

7. Surgery Has patient ever had surgery? □ No □ Yes

Date	Procedure or reason for surgery

Has patient ever had problems with anesthesia? □No □Yes Which one(s)?

8. Hospitalizations	
Was patient ever hospitalized? □No □Yes	
Date	**Procedure or reason for hospitalization**

9. Other Medical Issues	
Does patient have a regular dentist? □Yes □No	When was last dentist visit?
Does patient see any other specialist(s)? □Yes □No What for?	

10. Family History: List significant conditions (high blood pressure, heart problems, diabetes, depression, other psychiatric problems, substance abuse, specific types of cancer, or other diseases) among patient's BLOOD relatives.

Family member	Alive?	Age	Significant conditions
Father	□Yes □No		
Mother	□Yes □No		
Paternal grandfather	□Yes □No		
Paternal grandmother	□Yes □No		
Maternal grandfather	□Yes □No		
Maternal grandmother	□Yes □No		
Paternal uncle(s)	□Yes □No		
Paternal aunt(s)	□Yes □No		
Maternal uncle(s)	□Yes □No		
Maternal aunt(s)	□Yes □No		

How many brothers (including half-brothers) does patient have?
Do any of them have a significant health problem?

How many sisters (including half-sisters) does patient have?
Do any of them have a significant health problem?

10. Social History

Does anyone in the household smoke? □Yes □No
Does patient now or has s/he ever smoked? □Yes □No
If so, how much a day and for how long? _____
□ Cigarettes □Cigars □Pipe When did you quit?_____
Does patient now or has s/he ever used chewing tobacco? □Yes □No

Does anyone in the household drink alcoholic beverages? □Yes □No

Does anyone in the household use any street drugs, or prescription drugs obtained illegally? □Yes □No

Do any friends of the patient, or people the patient sees frequently/daily, use drugs or alcohol?

Please describe the kinds and amount of exercise the patient gets regularly, and indicate how often.

Please list patient's hobbies/other activities.
Who provides daycare or care outside of school?
Is patient sexually active? □Yes □No What is patient's sexual orientation? □ males □ females □ bisexual
Who lives with patient?
Tell us about patient's personal support network (the people s/he relies on).
Has patient been hit, kicked, punched or otherwise hurt by someone in the past year? □Yes □No Where? (At home, school…) Does patient feel safe in school or neighborhood? □Yes □No
Highest Grade Completed: _____ What kind of grades does patient get? Favorite class(es)?
Has patient had any overseas travel within the last year? □Yes □No If so, where?_____ Plans to travel overseas soon? _____ Where? _____

For parents: What concerns do you have about your child?

_____
_____
_____
_____
_____