Namaste Health Care

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New Patient Registration Packet

Date:___________________

Patient Name	Date of Birth	Age	Sex ☐ M ☐ F	Social Security #
Mailing Address		Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner		
City	State	Zip Code		Home Phone
Email Address	Work Phone			Cell Phone
Race ☐ American Indian/Alaskan Native ☐ Asian	☐ Native Hawaiian ☐ Black or African American		☐ White ☐ Hispanic	☐ Other (specify) ____________
Language preference ☐ English ☐ Spanish ☐ Other (please specify)____________________				
What is patient being seen for here today?				
Who is responsible for payment of patient's medical bill?				

<u>Insurance Information (please be sure we have a copy of any insurance card)</u>

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			

PHARMACY INSURANCE (Please Make Sure We Have A Copy of Your Card)

Pharmacy Insurance Company	Phone Number	Address

Employment Information for Patient □ Employed full-time □ Unemployed □ Employed part-time □ Self-employed □ Retired	Patient's Job Title	Student Information: Patient is a □ Full-time student □ Part-time student
Patient's Employer Name		Patient's Employer Phone Number

Emergency Contact			
Name		Their Relationship to Patient	Phone
Address	City	State	Zip Code

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.
Clinical Support – Heather Wren, L.P.N.
Office Support and Reception — Dawn Holzhauser
Clinical and Office Support – Tammi Ritta
Medical Assistant/Insurance Issues – 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 you have signed your consent to release.**

____ ______________

Patient/Legal Guardian Signature **Date**

By my signature, I am giving Dr. Early/Namaste Health Care permission to treat the patient above and to file a claim with my insurance company assigning benefits to Namaste Health Care.

Patient Health History

Today's Date: ______________

Full Name	Birth Date	Age today	Sex □ M □ F

Marital Status □ Single □ Married □ Divorced □ Widowed □ Legally Separated □ Partner

Do you have special health care needs/concerns to honor your faith or religious traditions? □ Yes □ No

If yes, what is your faith or religious affiliation? □ Christian □ Jewish □ Muslim □ Buddhist □ Other

1. Why is patient here today?

2. Is this because of a work-related injury? □Yes □No

If yes, date of injury:__________________________

Has patient had to stop working because of this problem? □Yes □No

Last day worked:____

Has Worker's Compensation claim or accident report been filed with employer? □Yes □No

If yes, please provide employer's phone number so we can contact them for information to file claim:

(If Worker's Compensation claim/accident report is **not** properly filed with employer, the patient will be held responsible for payment for any services rendered.)

3. What are the 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?

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

Medication	Dose (mg)	How often?	Who Prescribed?

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

5. Medical History

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

Preventive Care:

When were you last vaccinated or immunized for:

Tetanus ___________________________ Pneumonia ______________________________________

Influenza (flu) _______________________ Shingles (Zostavax vaccine) ________________________

Have you had a colonoscopy? ☐Yes ☐No If yes, when?
Where did you have it done?

Is patient pregnant? ☐ Yes ☐ No	Trying to become pregnant? ☐ Yes ☐ No	Breastfeeding? ☐ Yes ☐ No

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

Allergic or sensitive to	How does patient react to it?

7a. For Women Only

When was the patient's last diagnostic mammogram done? Where was it done?

Has she had a DEXA (a bone density scan)? ☐Yes ☐No When?

What were the results of this DEXA? Where was it done?

Date last period began?	Concerns about bleeding? ☐Yes ☐No	Recent changes in periods? ☐Yes ☐No
Last day of last period?	Are menstrual cycles ☐regular and predictable ☐ variable in length	Date of last Pap test? Has patient ever had an abnormal Pap test? ☐Yes ☐No If yes, when?

Age at time of first period?	What is method of birth control?	Has patient ever tested positive for HPV (human papillomavirus)? □Yes □No

Have she ever had a	If yes, how many?	
Miscarriage? □Yes □No	_____	How many living children in total? ______
Stillbirth? □Yes □No	_____	How many were vaginal deliveries? ______
Abortion? □Yes □No	_____	How many were C-section deliveries? ______
		Age at time patient first gave birth ______
Total number of pregnancies	______	Does patient have adopted children? □Yes □No
Total number of deliveries	______	If yes, how many? ________

What was patient's age at time of menopause? ___________ □ Not applicable

Has patient had bleeding after menopause? □Yes □No spotting? □Yes □No

Any concerns about sexual intimacy? □Yes □No

7b. For Men Only
Do you perform regular testicular self-exams? □Yes □No
Have you ever had a prostate specific antigen (PSA) blood test? □Yes □No

8. Other Health Care
Have you seen a dentist for a general check-up and teeth cleaning in the last 12 months? □Yes □No
Do you see any medical specialist(s)? □Yes □No What for? May we have you sign a release to obtain medical records from them and coordinate care with them?
When is the last time you had an eye exam? □ within the past year □ 1-2 years ago □ more than 3 years ago

9. Surgery Has patient ever had surgery? □ No □ Yes	
Date	Procedure or reason for surgery
Has patient ever had problems with anesthesia? No □Yes Which ones?	

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

11. 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 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?

How many sons does patient have?
How many daughters?
Do any of them have a significant health problem?

12. Social History

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 s/he now or has s/he ever used chewing tobacco? □Yes □No
Are you exposed to smoke in your home (does someone you live with smoke)? □Yes □No

Do you drink alcoholic beverages? □Yes □No
If so, when was the last time you had 4 or more (for women) or 5 or more (for men) drinks in one day?
□ Never □ More than 12 months ago □ 3 to 12 months ago □ Within the last 3 months

When and why did you quit? ____

Do you use any street drugs, or prescription drugs obtained illegally? □Yes □No
When and why did you quit? ____

How did you/do you consume these substances?
□ by mouth □ smoke □ IV (intravenous) □ Snort □ Other __________________

Do any friends, or people you see frequently or daily, use drugs or alcohol?

Please describe the kinds and amount of exercise you get regularly, and indicate how often.

Please list your hobbies/other activities.

Are you sexually active? □Yes □No

How many different sexual partners have you had in the last 5 years? ______

How many different sexual partners have you had in the last 4 months? ______

What is your sexual orientation? □ males □ females □ bisexual

Who lives with you?

Tell us about your personal support network (the people you rely on).

Have you been hit, kicked, punched or otherwise hurt by someone in the past year? □Yes □No

Do you feel safe in your home, at school, or in your neighborhood? □Yes □No

Is there a partner from a previous relationship who is making you feel unsafe now? □Yes □No

What is your occupation?

Have you ever been exposed to dangerous chemicals or toxins at work? Which ones?

Have you ever been exposed to dangerous levels of sound at work? □Yes □No

Highest Grade Completed: __________________ Degree: ___________________________

Have you traveled overseas within the last year? □Yes □No

If so, where?____

Plans to travel overseas soon? ______ Where? ___________________________________

13. Looking Ahead

Do you have a signed advance directive for medical care, a durable power of attorney, a signed designation of your medical proxy, and/or any other record of your wishes regarding your health care? □Yes □No

If yes, may we have a copy for our files?

If you wish to know more about these issues, we have information we can give you and we'll be happy to discuss them with you.

Do you have any other concerns or anything you would like your healthcare provider to know?

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