

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 <input type="checkbox"/>	N <input type="checkbox"/>		
Other Cancer	Y <input type="checkbox"/>	N <input type="checkbox"/>		
Diabetes	Y <input type="checkbox"/>	N <input type="checkbox"/>		
High Blood Pressure	Y <input type="checkbox"/>	N <input type="checkbox"/>		
Heart Disease/Stroke	Y <input type="checkbox"/>	N <input type="checkbox"/>		
Kidney Disease	Y <input type="checkbox"/>	N <input type="checkbox"/>		
Liver Disease	Y <input type="checkbox"/>	N <input type="checkbox"/>		
Blood Disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>		
Mental Illness	Y <input type="checkbox"/>	N <input type="checkbox"/>		
Alcoholism/Drug Abuse	Y <input type="checkbox"/>	N <input type="checkbox"/>		
Thyroid Issues	Y <input type="checkbox"/>	N <input type="checkbox"/>		
Cataracts/Glaucoma	Y <input type="checkbox"/>	N <input type="checkbox"/>		
Osteoporosis	Y <input type="checkbox"/>	N <input type="checkbox"/>		
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 <input type="checkbox"/>	N <input type="checkbox"/>	Measles/Mumps/Rubella/Chicken Pox/Mono/Strep	Y <input type="checkbox"/>	N <input type="checkbox"/>	Headaches/Numbness/Sensory Change/Head Injury
Y <input type="checkbox"/>	N <input type="checkbox"/>	Liver Disease/Hepatitis/Jaundice	Y <input type="checkbox"/>	N <input type="checkbox"/>	Epilepsy/Loss of Consciousness
Y <input type="checkbox"/>	N <input type="checkbox"/>	Gallbladder Disease/Gallbladder Stones	Y <input type="checkbox"/>	N <input type="checkbox"/>	Fatigue/Insomnia/Waking Not Rested
Y <input type="checkbox"/>	N <input type="checkbox"/>	Kidney Disease/Urinary Problems/Bladder Infections	Y <input type="checkbox"/>	N <input type="checkbox"/>	Poor Memory/Confusion/Foggy Mind
Y <input type="checkbox"/>	N <input type="checkbox"/>	Gonorrhea/Chlamydia/Herpes/ Genital Warts/Other Sexually Transmitted Disease	Y <input type="checkbox"/>	N <input type="checkbox"/>	Anemia/Nose Bleeds/Easy Bruising
Y <input type="checkbox"/>	N <input type="checkbox"/>	Pain/Impotence/Problems with Sexual Intercourse	Y <input type="checkbox"/>	N <input type="checkbox"/>	Hot Flashes/Night Sweats
Y <input type="checkbox"/>	N <input type="checkbox"/>	Ovarian/Uterine/Testicular Pain, Problems, or Masses	Y <input type="checkbox"/>	N <input type="checkbox"/>	Thyroid/Pituitary/Adrenal Problems
Y <input type="checkbox"/>	N <input type="checkbox"/>	Lung Disease/Shortness of Breath/Asthma/Tuberculosis	Y <input type="checkbox"/>	N <input type="checkbox"/>	Weight Loss/Gain (>10 Lbs.)



Patient Name: _____

- Y N Racing Heart/Chest Pain/High Cholesterol/Hypertension
- Y N Muscle Cramps/Tightness/Aches
- Y N Visual Changes/Eye Pain Infections/Cataracts
- Y N Ear Pain/Ear Infections/Decreased Hearing/Ringing
- Y N Joint Pain/Arthritis/Bone Loss/Bone Pain
- Y N Digestive Troubles/Pain/Gas/Bloating/Constipation/Diarrhea
- Y N Itching/Rashes/Eczema/Psoriasis/Mole Changes

- Y N Sinus Problems/Runny Nose/Allergies
- Y N Recurrent Colds/Flues/Infections
- Y N Cancer/Pre-Cancer of Any Kind
- Y N Skip Meals/Dieting/Binge Eating
- Y N Diabetes/Hypoglycemia/Sugar Craving
- Y N Depression/Anxiety/Irritability/Weepiness
- 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 ACKNOWLEDGEMENT

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: _____