MOUNTAIN VIEW NATURAL MEDICINE

Lorilee Schoenbeck, ND, PC Michael Gravett, ND Nicole Kearney, ND

ADULT REGISTRATION FORM

PATIENT INFORMATION

Name:_____ Preferred name: _____ Date of Birth:_____

Maiden name:_____ Family Ethnicity:_____

Street Address:_____City/State/Zip:_____ _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

May we leave a medically related message at home? _____ at work?_____ on cell?_____

Email Address:_____

What is your birth sex? Male_____ Female_____ Other (specify) _____

What gender do you identify as? Male_____ Female_____ Other (specify) _____

Referred by:_____ Pharmacy (include city):_____

Emergency Contact: _____ Phone Number:_____

GUARANTOR

(the person responsible for payment, if different than yourself)

Name:_____ Relationship to patient:_____

Address (if different):_____Phone:_____

INSURANCE INFORMATION

(please fill in even if you have brought your card with you)

Insurance Company:_____Subscriber:_____

Address:_____ Subscriber DOB:_____

Patient ID#:_____ Subscriber ID#:_____

Group #:_____ Patient's Relationship to Subscriber:_____

Subscriber's Employer / Address /Phone:_____

I authorize the release of any medical or other information necessary to process claims to my insurance carrier. I also request payment of government benefits either to myself or to the party who accepts assignment: Mountain View Natural Medicine. I authorize payment of medical benefits to Mountain View Natural Medicine for services rendered at this clinic and submitted to my insurance carrier.

Would you like us to be your primary care provider? Y / N

Name of other or prior PCP (Primary Care Provider) if applicable: _____

Please list your health concerns in order of priority along with other practitioners you may be seeing for the condition:

1._____

2._____

3._____

4._____

What do you believe is causing your most important health concerns?

PAST MEDICAL HISTORY: PLEASE LIST ANY SURGERIES AND/OR MAJOR ILLNESSES:

Age or date:	Description:

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications:	Reason:	Dose	Date began

Supplements:	Reason:	Dose	Date began

**Please list any drug allergies: _____

**Please list any food allergies_____

**Please list any environmental allergies: _____

Patients often desire communication between their healthcare providers. Do we have your permission to communicate verbally and in writing with other providers regarding your healthcare? yes / no

FAMILY HEALTH HISTORY: (be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)

Member	Living?/Age	Major illness or chronic conditions
Mother		
Father		
Siblings		
Mat. Grandmother		
Mat. Grandfather		
Pat. Grandmother		
Pat. Grandfather		

PREVENTATIVE HEALTH:
Please fill in what you can:

	Recent	Past year	Past 5 years
Weight			
Height			
Cholesterol w/ HDL & LDL			
Blood pressure			

If tested in the past 2 years, please check:
Thyroid (normal? y/n) _____ Blood sugar (normal? y/n) _____ Anemia (normal? y/n) _____
Date of last: Tetanus shot _____ Colonoscopy _____ (normal? y/n)

DIET: Please describe a typical day's diet for you, (be honest).

Breakfast	Lunch	Dinner	Snacks (what hour)

CURRENT HEALTH CONCERNS (Review of Systems)
Please check normal or abnormal and briefly explain.

N ABN

__ __ Constitutional (Energy, weight, body temperature, sleep, general sense of well-being) _____
_____
__ __ Head: headaches, vertigo, injuries etc.)_____
__ __ Vision/eye problems: _____
__ __ Ear/nose/throat/mouth (allergies, infections etc.)_____
__ __ Cardiovascular: (high BP, cholesterol etc.) _____
__ __ Respiratory_____
__ __ Digestive tract issues: (changes in bowel habits, hemorrhoids, bloating, pain, etc.) _____
_____
__ __ Musculoskeletal concerns (arthritis, joint problems, osteoporosis, muscle pain, weakness):_____
_____
__ __ Skin (eczema, infections, rashes, etc.) _____
__ __ Psychological (mood changes, sadness, irritability, anxiety etc.) _____
_____
__ __ Neurological (numbness, tingling, balance problems, memory etc.) _____
_____
__ __ Hormonal issues (diabetes, thyroid problems, menopausal, adrenal etc.) _____
_____
__ __ Blood or lymph issues (current anemia, swollen glands etc.) _____
__ __ Allergies _____
__ __ Others:_____
__ __ Urinary (pain, incontinence, trouble starting urination):_____

Sexual History:
Are you currently sexually active? _____ Partner(s) is/are (ex/ male, female, transmales, etc): _____
What is your sexual orientation:_____
Any problems related to sexual function/libido? _____
Do you have a history of sexually transmitted disease? _____ Genital warts? _____

Gynecologic History:
Onset of first menses was age___. Periods generally last ___ days and occur every ___ days.
Date of last period _____ Bleeding is __Heavy __Moderate __Light?
Do you experience PMS symptoms? _____ List:_____
Type of birth control: _____ Are you happy with this method? _____
Are you currently experiencing any gynecological symptoms or problems? _____
_____
Number of pregnancies?_____ Births?_____ Abortions?_____ Miscarriages?_____
Date of last Pap smear: _____ Abnormal Pap History? _____
Do you perform regular breast self exams? _____ Date of last mammogram, if any: _____

If menopausal or perimenopausal, list symptoms and concerns: _____

LIFESTYLE

Relationship status: single____married_____civil union_____other_____
What is your vocation? _____
What are your primary sources of stress? _____
_____
How much do you think they impact your life? _____
How many hours do you work per week? _____ Number of play/relaxation hours? _____
What do you do in order to manage stress and take care of yourself? _____
_____
What is your exercise routine? _____
Do you wear seatbelts? Y/N A bike helmet? Y/N
What do you do for fun? _____
Caffeine/Amount? _____Alcohol/Amount? _____
Smoking history and amount? _____ Recreational drugs? _____

Take a minute to imagine what good health means to you. What would it look like if all the health concerns you currently have were successfully solved? What would you be able to do? How would you feel?

What specific change(s) are YOU ready to make in order for you vision of health to happen?

What, if any, barriers to this exist? How could you overcome these?

How ready do you feel to make the changes above, on a scale from 1-10?
1 2 3 4 5 6 7 8 9 10 (1=not sure, 5=depends how hard it is, 10=I'll do what it takes!)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Mountain View Natural Medicine has provided me with
a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed,

and how I can access this information. I understand that if I have questions or complaints I may contact the
Office Manager @ 802-860-3366.

I also understand that I am entitled to receive updates upon request if Mountain View Natural Medicine amends
or changes its Notice of Privacy Practices in a material way.

_____	_____
Signature	Relationship to Patient, if other than patient
_____	_____
Date	Patient's name if not signed by patient

THIS SECTION IS TO BE COMPLETED BY an employee at Mountain View Natural Medicine IF <u>UNABLE</u> TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____	_____
Name and title of employee	Date

Financial Policy

PAYMENT IS EXPECTED WHEN YOU COME IN FOR AN APPOINTMENT

- Co-Payments, deductible, co-insurance and private pay fees, where applicable are due upon check out.
- Any deductible is due at visit.
- Note that one Preventive Visit for screening is provided annually by most insurers. If you need to discuss treatment, you'll need a "problem-focused visit" and co-pay, deductible or co-insurance will be due.
- You are responsible for understanding what your insurance plan will cover or not cover
- As a courtesy, we will submit non-participating insurance companies and reimburse you if they pay us.

- Postage and handling will be added to mailed dispensary items. We require payment prior to mailing.

NOTIFY US OF ANY CHANGES IN YOUR ADDRESS AND/OR INSURANCE

- If your insurance changes, bring your new insurance card with you.
- Please contact your insurance company with insurance questions.

STATEMENTS ARE GENERATED FOR OUTSTANDING BALANCES

- If you are responsible for more than one patient account, we may offset an overpayment in one account to another account.
- We will assess a **$25.00 fee** for any checks returned unpaid.
- If payment is not received within 21 days of the statement date your account will be considered delinquent

WE USE COLLECTION AGENCIES FOR DELINQUENT ACCOUNTS

- If your account is delinquent, we may list your default with our credit reporting agency. If we incur any collection costs, these will be added to the balance you owe.

NOTIFY US TO CANCEL AN APPOINTEMNT

- If you need to cancel an appointment, please notify us 24 hours before the appointment.
- If you miss an appointment or are late in cancelling it, we may assess a **$50.00 fee.**
- If you frequently miss or cancel appointments, you may be discharged from the practice.

WE USE AND AUTOMATED SYSTEM FOR E-MAIL APPOINTEMNT REMINDERS

- An automated e-mail will be sent to the listed e-mail address prior to your appointment.
- A courtesy phone call made by office staff will be given 48 hours prior to an appointment.

RETRUNED SUPPLEMENTS

- Any unopened item may be returned for a full refund within 30 days of purchase.
- Mail order items must be postmarked by 30 days of the original date of purchase. Return postage is nonrefundable.

I've read the above financial policy of Mountain View Natural Medicine and agree to its terms. I am responsible for any balance due on my or my dependents account.

Patient Name: _____Signature/Date:_____

Responsibility party name: _____ Signature/Date:_____

Appointment Policy

MISSED APPOINTMENT / LATE CANCELLATION:

MVNM requires 24 business hours of notice for all missed appointments. Appointments missed

will incur a $50 missed appointment fee.
Current patients who miss 3 appointments in a year will be released from our care and will get a referral to a new practice.
Patients who miss their initial New Patient Exam are subject to the same missed appointment policy. However, New Patients who miss TWO appointments for their initial exam will no longer be accepted as new patients in our clinic.

TARDINESS:

If a patient is more than 15 minutes late, they will need to be rescheduled. The appointment will count as a missed appointment and will incur a $50 missed appointment fee.

CANCELLATION:

MVNM kindly requests a minimum of 24 business hours of notice when changing or cancelling an appointment. Appointments cancelled inside of 24 hours will be counted as a missed appointment and are subject to the $50 missed appointment fee.

I, _____, understand MVNM's policy on missed appointments, cancellations, and tardiness. If I miss an appointment, show up late, or cancel with less than 24 hours of notice I agree to pay the $50 fee as outlined above.

_____ _____

Patients Signature Date