

Monadnock Natural Medicine
Patient Registration Form
Patient Information

Last Name: _____ First Name: _____ MI: _____
Maiden Name: _____ Date of Birth: _____ Sex: _____
Street Address: _____
City: _____ State: _____ Zip: _____ SS#: _____
Employer/School: _____ E-mail Address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Mother's Name (minors only): _____ Father's Name: _____
Emergency Contact: _____ Contact's Phone #: _____
Emergency Contact is my: (specify relationship) _____
How did you hear about us? *Newspaper Ad* *News Story* *Mailer/Flyer* *Website*
(Circle one) *Workshop/Event* *Medical Referral* *Friend/Family* *Yellow Pages*

Responsible Party Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Name: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____

Acknowledgment of Receipt

Monadnock Natural Medicine is required to provide you with a copy of our Notice of Privacy Practices and to obtain written acknowledgment, if possible, that you have received it. The Notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights, and explains how you may exercise those rights.

I hereby acknowledge that I have received a copy of Monadnock Natural Medicine's Notice of Privacy Practices. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

Patient's Name (PRINT)

Patient's Guardian/Representative (PRINT)

Signature of Patient

Signature of Guardian/Representative

Date

Relationship to Patient/Representative Authority

Date

Insurance Information:

Insurance Company: _____ Insurance Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
ID Number: _____ Group Number: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Patient's Relation to Subscriber: (circle one) Self Spouse Child

FOR OFFICE USE ONLY: Unable to Obtain Acknowledgment of Receipt

This section serves as a record of Monadnock Natural Medicine's good faith effort to obtain written acknowledgment from the patient of receipt of the Notice of Privacy Practices.

Patient was given a copy of the notice on: _____

Patient refused to sign acknowledgment

Patient is physically unable to sign acknowledgment

Other: _____

Monadnock Natural Medicine

Pediatric Patient Profile

Last Name: _____ First Name: _____ MI: _____
 Nickname: _____ Date of Birth: _____ Age: _____ Sex: _____

Present Health Concerns

Please list your child's health concerns in order of priority, including date of onset and severity of symptoms.

1. _____
2. _____
3. _____
4. _____
5. _____

What do you believe is causing your child's most important health concerns? _____

What goals do you have for your child's visit today? _____

Healthcare Practitioners: Please list your child's current medical practitioners with their contact information.

	Practitioner's Name	Office Name	City	Phone
Pediatrician				
Specialist				
Specialist				
Therapist				
Pharmacy				

Medications: Please list any prescription drugs, over-the-counter medications and supplements (vitamins, minerals, nutrients, herbs, homeopathic remedies, etc.) you child is currently taking.

Medication/Supplement	Reason	Date Began	Dose

Allergies: Please list and describe any severe or life-threatening allergies (medications, stings, foods, etc.):

 _____ **(OVER)**

Past Medical History: Please list the date of or age at each event and describe:

Serious Illnesses and Injuries: _____

Surgeries: _____

Hospitalizations: _____

Date of last physical: _____ Date of last blood tests: _____

Childhood Illnesses: Your child's health is: Good Fair Poor

Chicken Pox	Mononucleosis (Mono)	Rheumatic Fever
Diphtheria	Mumps	Tonsillitis
Ear Infections	Pertussis (whooping cough)	Scarlet Fever
German Measles (Rubella)	Pneumonia	Strep Throat (recurrent)
Measles	Polio	Positive TB test
Other: _____		

Immunizations: Indicate which immunizations have been given to your child and any adverse reactions.

All immunizations up to date Delayed schedule Refused immunizations

DTP or DTaP _____	Pneumococcus (PCV) _____
MMR _____	Hep B _____
Polio (IPV or OPV) _____	Varicella _____
Hib _____	Other _____

Pregnancy History: Birth Mother: # of pregnancies: _____ # of children: _____ Age at delivery: _____

Please check any factors during pregnancy. Health during pregnancy: Good Fair Poor

Alcohol Consumption	Nausea	Toxemia
Bleeding	Recreational Drugs	Trauma/Injury
High Blood Pressure	Smoking	X-Ray
Stress	Medications: _____	

Other health problems or complications during pregnancy: _____

Birth History:

Term: Early _____ weeks Full Term Late _____ weeks Length of labor: _____ hours

Place of Birth: Hospital Birth Center Home Other: _____

Birth Medications (if any): _____

Complications: _____

Newborn: Weight at birth: _____ lbs _____ oz Home from hospital in _____ days

Jaundice	Infection	Seizures
Cyanosis	Fever	Anemia

Other important conditions: _____

Feeding: Breast Fed _____ months Formula Fed _____ months Type of formula _____

Developmental Milestones: Please indicate your child's age at each milestone:

Sit up _____ months	First Tooth _____ months	Toilet Trained _____ months
Crawl _____ months	First Word _____ months	
Walk _____ months	First Sentence _____ months	

Additional comments about social, cognitive, or physical development: _____

(OVER)

Personal and Family Medical History:

Please check the box next to each condition that applies to your child or his/her biological family members.

Key: P=Paternal; M=Maternal; GF=Grandfather; GM=Grandmother

	YOU	Mom	Dad	Grandparents				Siblings and Children				
				PGM	PGF	MGM	MGF					
Current Age or Age at Death												
Alcohol / Drug Abuse												
Allergies or Hay Fever												
Alzheimer's or Dementia												
Anemia												
Anxiety / Panic Attacks												
Arthritis / Joint Disease												
Asthma												
Autoimmune Disease												
Bleeding Disorder												
Cancer (What Type?)												
Celiac Disease												
COPD / Emphysema												
Depression/Suicide Attempt												
Diabetes												
Eczema												
Epilepsy or Seizures												
Glaucoma												
Gall Bladder Disease												
Migraines / Headaches												
Heart Attack												
Heart Disease												
High Blood Pressure												
High Cholesterol												
HIV / AIDS												
Inflammatory Bowel Disease												
Kidney Disease												
Liver Disease / Hepatitis												
Macular Degeneration												
Osteoporosis												
Schizophrenia												
Stroke												
Thyroid Disorder												
Other:												

Social History

Parents: Biological Adoptive Foster Step-parent(s)

Parents' Marital status: Single Married Divorced Re-married Widowed Significant Other

Mother's Occupation: _____ Full or Part Time Father's Occupation: _____ Full or Part Time

Siblings: Yes No Please list their age(s) _____

Household: Parent(s) Sibling(s) Grandparent(s) Pet(s) _____

Other _____

Pre-School/Daycare/School: _____ Hours per day: _____ Days per week: _____

Personality and Habits:

How does your child react to stressful events? _____

What are your child's primary sources of stress? _____

How much does stress impact your child's life? _____ Hours of play per day? _____

Favorite activities? _____

Does your child:

Exercise regularly? Yes No What kind? _____

Sleep soundly and wake rested? Yes No If no, why? _____

Sleep: _____ hours per night Naps: _____ hours per day

Play well with others? Yes No If no, why? _____

Enjoy time alone? Yes No If no, why? _____

Have sensory sensitivities? Yes No What kind? _____

Have strong fears or phobias? Yes No What kind? _____

Have rituals/repetitive behaviors? Yes No What kind? _____

Diet:

Age Solid Foods Begun: _____ months First Foods: _____

Age of Introduction for: Dairy (cow's milk) _____ months Wheat: _____ months

Does your child have any dietary restrictions? _____

Your child's favorite foods? _____

Foods your child refuses? _____

How is your child's appetite? _____ Thirst? _____

Please describe a typical day below:

Breakfast Time: _____	Lunch Time: _____	Dinner Time: _____	Snacks Times: _____

Water: _____ oz. per day Other beverages: _____

What else would you like us to know about your child?

This form has been reviewed by the doctor with the parent.

Signature of Parent

Date

Signature of Doctor

Date

Monadnock Natural Medicine

Consent for Treatment

The naturopathic doctors at Monadnock Natural Medicine may perform, order, or prescribe any of the following procedures and therapies as necessary to properly evaluate, diagnose and treat your health concerns:

General Diagnostic Procedures: including, but not limited to, physical exams, diagnostic imaging (X-rays, ultrasound, etc.), venipuncture, pap smears and other specimen collection for diagnostic labwork.

Psychological and Lifestyle Counseling: promotion of wellness using recommendations for exercise, sleep, stress management and balancing of work and social activities.

Botanical and Homeopathic Medicines: use of therapeutic plant substances in oral and topical forms and homeopathic remedies (dilute quantities of naturally occurring plant, mineral and animal substances) in oral and topical forms.

Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements. May include intramuscular vitamin injections and intravenous nutrient therapy.

Soft Tissue and Osseous Manipulation: use of massage, neuromuscular techniques, muscle energy stretching, craniosacral therapy or visceral manipulation, and manipulations of the extremities and spine.

Prescription Items: pharmaceutical medications contained within the New Hampshire naturopathic formulary, barrier contraceptives, and immunizations.

Potential Risks: including, but not limited to, pain, discomfort, blistering, discolorations, infection, burns, fainting or tissue injury from needle insertions, topical procedures, heat or frictional therapies; adverse reactions to prescribed herbs or supplements such as allergic reaction, headache, nausea; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: including, but not limited to, restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention and management of disease.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy.

I hereby authorize the naturopathic doctors at Monadnock Natural Medicine to perform, order, or prescribe the above procedures and therapies as necessary to facilitate my diagnosis and treatment. I understand that I may ask questions regarding my individual treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic doctors at Monadnock Natural Medicine.

Patient's Name (PRINT)

Patient's Guardian/Representative (PRINT)

Signature of Patient

Signature of Guardian/Representative

Date

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Date



Monadnock Natural Medicine, PLLC
holistic health care for the whole family

Notice to all Cigna and Blue Cross Blue Shield insurance patients:

Naturopathic Doctors are considered to be specialists by Cigna, and are therefore unable to act as a Primary Care Doctor for patients with these insurances. As a result, we are unable to submit insurance claims for Wellness Checks or for preventative appointments.

Please note: HMO insurance policies with Cigna DO NOT provide coverage for Naturopathic Services, and patients with these insurances must pay for services at the time of their appointment.

Please be aware that not all visits or procedures will be covered by insurance. Important: until we can verify your insurance coverage, payment is due in full at the time of your visit. If your insurance company denies payment for any portion of your bill for any reason, you are responsible for the cost of treatment at the current rates.

We must know PRIOR to your appointment if you wish the visit to be covered by insurance in order to allow us time to verify your coverage. Unfortunately we are unable to submit claims for previous visits. We are unable to provide information regarding type, amount, or timing of insurance reimbursements.

Patients with insurance that requires a co-insurance (a percentage of the invoice total), MUST speak to their insurance company prior to an appointment in order to understand what their individual plan details are, especially as relates to deductibles.

Payment is due in full at the time of your visit. For your convenience we accept cash (exact change appreciated), check, Visa, Mastercard, Discover and American Express.

I have read, understand and agree to the above policies. I also agree that I have had the opportunity to discuss all fees and payment options, and understand my responsibility for payment of services rendered.

Patient Signature

Date

Monadnock Natural Medicine

How Do I Check My Insurance Benefits?

Patient Name _____ **Insurance ID#** _____
Insurance Company _____

Our clinic will happily bill your insurance for your visit; however, it is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximums. Please follow steps 1-6 when calling to find out benefits and eligibility.

First, Call the number on your insurance card listed for customer service, benefits and eligibility, or Subscriber services and ask the representative the following questions:

1. When did my coverage begin and when is it valid thru?

Beginning Date of Coverage _____ Ending Date of Coverage _____

2. Do I need a referral from my primary care physician (PCP) for alternative services?

_____ Yes _____ No

3. What are my benefits for the following services? *

Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending on whether the doctor is In or Out-of-Network with your Insurance company and whether your plan includes Out-of-Network benefits.

Naturopathic: % Covered _____ Co-pay/ Co-Insurance _____ Year Max _____

4. What is my deductible for the year and has any or all of it been met?

Deductible \$ _____ Amount of Deductible met so far \$ _____ Date _____

5. What was the name of the representative I spoke with: _____ Date _____

* Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance. Thanks so much!