WELCOME!!

New Patient Information

Please help me to learn as much as possible about you so that I can best meet your needs.

Name ____ Gender______________

Address______________________________________ Phone_______________

City, State, Zip _________________________________ Work Phone__________

Fax__________________ E-mail____

Birthdate_______________________ SS#___________________________

Emergency contact____________________________ Phone_______________

Relationship______________________________

Primary Insurance_________________ ID#_______________ Group/Policy#_______

Subscriber name____________________ Relationship________ Birthdate______

Subscriber SS# _______________________ Insurance Phone __________________

Secondary Insurance_________________ ID#_______________ Group/Policy#______

Subscriber name____________________ Relationship________ Birthdate_______

Subscriber SS# _______________________ Insurance Phone __________________

Please advise if our office is:

_______ Participating _________ Non-Participating with your Insurance Carrier.

I accept full responsibility for all charges incurred for any and all services furnished and/or "no-show" appointments. I understand that if my insurance is billed, I authorize payment of medical benefits to Holistic & Integrative Family Medicine (Dr. Sue Stone). I understand that if my insurance is billed, I authorize release of any medical or other information necessary to process this claim and to determine the benefits payable to related services. If my insurance is not billed, I agree to render payment for service at the time of service. I understand that I am totally responsible for all charges that are not paid by my insurance plans. I understand that I am totally responsible for the Medicare deductible and any deductible for supplemental insurance which must be met each year. I understand that a "Notice of Information Practices" is available upon request.

_________________________ _______________________

Signature of responsible party Patient's name

Describe your family and your relationships with them:

How is life at home? ____

What kind of work do you do? ____________________________________

Do you enjoy your job? ____

How did you hear about this practice? ________________________________

____

Medical History

Medical illnesses/ issues/ injuries:

____

____

____

____

____

Surgeries:

____

____

Hospitalizations (last 10 years):

____

____

Other physicians you see:

____

____

____

Other health practitioners/healers:

____

____

____

Allergies to medications, foods, etc (what reaction?):

Medications you currently take:

Vitamins/Supplements/Herbs currently taking (bring them with you please):

Lifestyle

What do you eat? ("diet is everything"):

Exercise? ______________________________

Tobacco? (ever?) ______________________________

Alcohol? (ever?) ______________________________

Clean & Sober? ______________

How well do you sleep? ______________________

What do you do when you can't sleep? ____________________

How would you rate your stress level? ______________________________

How do you deal with stress?

How do you nurture (take care of) yourself?

How is your energy level?

Family History

What illnesses do other family members have? (cancer, diabetes, heart disease, alcoholism, osteoporosis, etc..........)

Review of systems

Do you struggle with:

1. depression ___
2. your weight ___
3. anxiety ___
4. digestion ___
5. fatigue ___
6. insomnia ___
7. headaches ___
8. skin problems ___
9. back or neck pain ___

Are you concerned about:

chest pains ___

difficulty breathing___

vision___

hearing___

urination___

menstrual problems___

sex___

other:

Women: # of pregnancies ___

# of live births _____

other pregnancy outcomes______________________________

date of last menstrual period _________________

Spirituality

What are your spiritual and/or religious beliefs? Do you belong to a church? Do you pray? Do you meditate? How do you see this as impacting your health?

Is there anything else you want to tell me about yourself?