

# Crabapple Integrative & Internal Medicine

## PERSONAL INFORMATION

TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CELL (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

WORK (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ EXT. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX  F  M SOCIAL SECURITY # \_\_\_\_/\_\_\_\_/\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_

MARITAL STATUS:  SINGLE  DIVORCED  LEGALLY SEPARATED  PARTNER  
 MARRIED (SPOUSE NAME \_\_\_\_\_)  WIDOWED  UNKNOWN

EMPLOYER NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

EMPLOYMENT STATUS:  FULL TIME  NOT EMPLOYED  RETIRED  
 PART TIME  SELF EMPLOYED  ACTIVE MILITARY

STUDENT STATUS:  FULL TIME  PART TIME

**RESPONSIBLE PARTY:**  SELF  GUARANTOR RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

## **EMERGENCY CONTACT:**

NAME LAST \_\_\_\_\_ FIRST \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

THEIR HOME PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ THEIR WORK PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ EXT. \_\_\_\_\_

## **ADDITIONAL INFO**

EMAIL ADDRESS \_\_\_\_\_ (will not be shared)

AUTHORIZATION TO RELEASE INFORMATION TO: NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PHARMACY: NAME \_\_\_\_\_ LOCATION \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I authorize *Crabapple integrative and Internal Medicine* and my insurance company to release any information required to process my claims.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Crabapple Integrative & Internal Medicine

What are your most important health concerns? \_\_\_\_\_

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How did you hear about our clinic? \_\_\_\_\_

## Personal History

What hospitalizations or surgeries have you had? \_\_\_\_\_

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What diagnostic imaging studies have you had?  X-rays  CT scan  PET scan  MRI  Endoscopy  
 Colonoscopy  Sigmoidoscopy  Bone density scan  Mammogram  EKG/ECG  EEG

Were there any significant findings?

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Please list any **prescription medications**, over-the-counter medications, vitamins, or other supplements you are taking:

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Are you aware of any **allergies** to food, drugs, or other environmental allergens (cats, mold, and dust)? If yes, please list and explain:

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## Childhood Illnesses

Please circle whether you have/had any of the following conditions as a child/adolescent:

Diphtheria	Mumps	Polio	Rubella
German measles	Rheumatic fever	Pertussis	Chronic Ear or Throat
Measles	Scarlet fever	Chicken Pox	infections
Other _____			

## Past Immunizations

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diphtheria	Polio	Hepatitis A/ B
Measles/Mumps/Rubella (MMR)	Tetanus	H1b
Pertussis	Varicella (Chicken Pox)	Influenza; annually? Yes / No
Other(s) _____		

# Crabapple Integrative & Internal Medicine

## Family History

Do you have a family history of any of the following (please circle)?

Anemia	Diabetes	Goiter	Kidney disease
Arthritis	Epilepsy	Hay fever/hives	Liver disease
Asthma	Gall bladder disease	Heart disease	Mental illness
Cancer	Glaucoma	Heart murmur	Stroke
Cataracts	Gluten Sensitivity	High blood pressure	Tuberculosis

Is your father still living? Yes; his age \_\_\_\_ No; age at time of death \_\_\_\_ Cause of death \_\_\_\_\_  
 Is your mother still living? Yes; her age \_\_\_\_ No; age at time of death \_\_\_\_ Cause of death \_\_\_\_\_

## Review of Systems

Please circle. Y= Yes, present condition P=Problem of the past N=No, never had the condition.

### Head

Headaches	Y P N	Migraine headaches	Y P N
Head injury	Y P N	Jaw/TMJ problems	Y P N

### Ear

Ringling	Y P N	Dizziness\	Y P N	Frequent wax build up	Y P N
Earaches	Y P N	Impaired hearing	Y P N	Itchy or moist ears	Y P N

### Eyes

Blurred vision	Y P N	Cataracts	Y P N	Glasses/contacts	Y P N
Eye pain/strain	Y P N	Glaucoma	Y P N	Tearing/dryness	Y P N
Spots in eyes	Y P N	Color blind	Y P N	Double vision	Y P N

### Nose/Sinuses

Stuffiness	Y P N	Loss of smell	Y P N	Sinus problems	Y P N
Hayfever	Y P N	Nose bleeds	Y P N	Frequent discharge	Y P N

### Mouth/Throat

Hoarseness	Y P N	Gum problems	Y P N	Freq. sore throat	Y P N
Jaw clicks	Y P N	Dental cavities	Y P N	Sore lips/tongue	Y P N
Dry Mouth	Y P N				

### Neck

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N

### Skin

Rashes	Y P N	Psoriasis	Y P N	Eczema, hives	Y P N
Lumps	Y P N	Acne, boils	Y P N	Color changes	Y P N
Itching	Y P N	Loss of hair	Y P N	Night sweats	Y P N

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## Respiratory

Asthma	Y P N	Wheezing	Y P N	Spitting up blood	Y P N
Cough	Y P N	Bronchitis	Y P N	Difficulty breathing	Y P N
Sputum	Y P N	Pneumonia	Y P N	Pain with breathing	Y P N
Pleurisy	Y P N	Emphysema	Y P N	Shortness of breath	Y P N
Tuberculosis	Y P N	Difficulty breathing while lying down at night	Y P N		

## Cardiovascular

Angina	Y P N	Chest pain	Y P N	Blood clots	Y P N
Murmur	Y P N	Heart disease	Y P N	Rheumatic fever	Y P N
Fainting	Y P N	Ankle swelling	Y P N	Low/high blood pressure	Y P N
Anemia	Y P N	Cold hands/feet	Y P N	Thrombophlebitis	Y P N
Leg pain	Y P N	Easy bruising	Y P N	Varicose veins	Y P N

## Gastrointestinal

Diarrhea	Y P N	Constipation	Y P N	Ulcers	Y P N
Black stool	Y P N	Coughing up blood	Y P N	Jaundice	Y P N
Hemorrhoids	Y P N	Gall bladder disease	Y P N	Heartburn	Y P N
Abdominal pain	Y P N	Blood in stool	Y P N	Liver disease	Y P N
How many bowel movements per day? _____ Are they generally: loose well-formed dry and hard pebble-like					

## Urinary

Incontinence	Y P N	Frequent infections	Y P N	Painful urination	Y P N
Kidney stones	Y P N	Frequency at night	Y P N	Change in color / odor	Y P N

## Musculoskeletal

Joint pain	Y P N	Muscle spasms	Y P N	Stiffness	Y P N
Arthritis	Y P N	Muscle pain/soreness	Y P N	Broken bones	Y P N
Sciatica	Y P N	Muscle weakness	Y P N		

## Neurological

Fainting	Y P N	Paralysis	Y P N	Numbness/tingling	Y P N
Seizures	Y P N	Loss of memory	Y P N	Muscle weakness	Y P N

## Emotional

Mood swings	Y P N	Nervousness	Y P N	Tension/stressed	Y P N
Anxiety	Y P N	Depression	Y P N	Loss of loved one	Y P N

## Endocrine

Hypothyroid	Y P N	Excessive thirst	Y P N	Cold intolerance	Y P N
Hyperthyroid	Y P N	Excessive hunger	Y P N	Heat intolerance	Y P N

# Crabapple Integrative & Internal Medicine

## Male Reproductive

Hernias	Y P N	Testicular masses	Y P N	Discharge or sores	Y P N
Prostate issues	Y P N	Sexual difficulty	Y P N	Testicular pain	Y P N
Premature Ejaculation	Y P N	Sexually transmitted disease/infections	Y P N	Blood in semen	Y P N

## Female Reproductive

Age of first menses \_\_\_\_\_ Age of last menses (if menopausal) \_\_\_\_\_  
Length of cycle \_\_\_\_\_ Duration of menses \_\_\_\_\_  
Date of last annual exam \_\_\_\_\_

Painful menses	Y P N	Endometriosis	Y P N	Ovarian cysts	Y P N
Heavy flow	Y P N	Fertility issues	Y P N	Cervical dysplasia	Y P N
Breasts tender	Y P N	Venereal disease	Y P N	Bleeding between cycles	Y P N
Sexually active	Y P N	Cycles regular	Y P N	Menopausal symptoms	Y P N
Sexual difficulty	Y P N	Abnormal pap	Y P N	PMS	Y P N
Breast lump(s)	Y P N	Nipple discharge	Y P N	Do self breast exams	Y P N

Birth control Y P N If yes, what type? \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_

## Environmental

Circle any of the following you routinely use at home: Gas heat Oil heat Electric heat Wood stove Air conditioning Electric blanket T.V. Distilled/ Filtered/ Spring/ Well/ Deionized/ Tap water

Is your home and work environment well ventilated? \_\_\_\_\_

Is your home or work environment excessively damp or moist? \_\_\_\_\_

Has there been any known mold growth, leaks, or large spills in your living or work area? \_\_\_\_\_

Please circle any of the following you feel most bothered by: Cold Heat Seashore Dust/Mold Cat or Dog hair Car fumes Poor air/ventilation Spring Summer Fall Winter Change in weather (specify) \_\_\_\_\_ Chemicals (specify) \_\_\_\_\_

Other (specify) \_\_\_\_\_

Do you get outdoors daily, even in the winter? \_\_\_\_\_

How do you feel about your work? Do you enjoy it, are you satisfied and fulfilled by it, does it provide you with the necessities of life, is it just a job you feel you must put in the hours in order to make a living? \_\_\_\_\_

Have you ever lived in or near an industrial area, waste management area, known environmentally contaminated area? \_\_\_\_\_

Have you ever worked with chemicals, pesticides, solvents, plastics, resins, metals, etc? \_\_\_\_\_

Do any of your hobbies include the use of chemicals, pesticides, solvents, plastics, resins, metals, etc? \_\_\_\_\_

Is there anything else you would like us know in order to serve you better? \_\_\_\_\_

# Crabapple Integrative & Internal Medicine

## RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, \_\_\_\_\_, have been informed that a copy of *Crabapple Integrative and Internal Medicine Notice of Privacy Practices*, is posted in the waiting room area. A copy of this **Notice** will be furnished to me upon my request.

Patient Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, (a Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding: unique identifiers for health plans, providers, individuals, employers, healthcare transaction & code sets for transmitting data electronically, privacy regulations over disclosure and use of health information. Security regulations over protections of electronic health information

It is our policy to **not** release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself, please complete the following

I authorize *Crabapple Integrative and Internal Medicine* to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Voice Mail	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Answering Machine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cell Phone/Voice Mail	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Work Telephone	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pager	<input type="checkbox"/> YES	<input type="checkbox"/> NO

May we fax medical records for your referrals?  YES  NO

Please list names of people with whom we may discuss your medical care:

Spouse Name \_\_\_\_\_  YES  NO

Parent Name \_\_\_\_\_  YES  NO

Other Name \_\_\_\_\_  YES  NO

### **RELEASE OF MEDICAL RECORDS/IMAGING:**

I authorize release of medical and related information including alcohol, drug abuse and mental health records obtained in the course of diagnosis and treatment to the insured's insurance carrier(s), agencies and their intermediaries or carriers, if applicable, for the purpose of obtaining care, treatment or payment for services provided or to be provided. This information may be released via USPS first class mail, facsimile or certified courier, as applicable. Authorization may be withdrawn at any time by written notification.

I authorize the release of nay and all information/records/x-rays, etc. need to evaluate my condition. I further request that this and any other pertinent information be forwarded to *Crabapple Integrative and Internal Medicine*.

**REQUEST FOR MEDICAL CARE:** I voluntarily consent to examination, lab evaluation, treatment and the rendering of care, including treatments and performance of diagnostic procedures. I grant my consent for treatment for myself, my spouse, or my minor children/dependent as listed on this form.

**Patient Name:** \_\_\_\_\_

**Patient or Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Crabapple Integrative & Internal Medicine

## Scent-Free Policy

Many of our patients have the medical diagnosis of Multiple Chemical Sensitivity (MCS) and are EXTREMELY sensitive to chemical smells of any kind, including fragrances and tobacco smoke. **Exposures to these smells can result in serious consequences for them such as seizures, nausea, vomiting, severe headaches, vertigo and many others.**

In fairness to all of our patients, IT IS OF UTMOST IMPORTANCE that you do not wear perfume, cologne, aftershave, hair spray, hand cream or lotion, or any other scented personal care products to our office. Please do not wear clothing that may have lingering odors of cologne, perfume, fabric softener, detergent or tobacco.

Our scent-free policy also applies to anyone who may be accompanying you to our clinic. **You may be asked to reschedule your appointment if you come to the office with a scent.**

We greatly appreciate your understanding and agreement to adhere to our "Scent-Free Policy".

*I have read and understand the Scent Free policy of Crabapple Integrative and Internal Medicine and agree to adhere to these recommendations.*

**Patient Name:** \_\_\_\_\_

**Patient or Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Crabapple Integrative & Internal Medicine

## Financial Policy

Our goal at *Crabapple Integrative and Internal Medicine* is to make sure your health care experience is delivered with thoroughness and the utmost in quality. We want to keep your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

- 1) You are ultimately responsible for payment of services rendered from our office at time of service. Please contact your insurance company to confirm coverage and benefits. It is the responsibility of the insured to be aware of the limits of coverage by his or her insurance carrier prior to your visit. We can NEVER guarantee coverage for any service provided by our office. There are no contractual adjustments taken as this practice does not participate with any insurance carriers.
- 2) It is your responsibility to provide us with your current address, telephone number at each visit.
- 3) A 24-hour notice is required if you are unable to keep your appointment to avoid a \$25.00 charge.
- 4) There is a \$35.00 fee for checks not honored by your bank.

***I understand and accept the Financial Policy listed above.***

**Patient Name:** \_\_\_\_\_

**Patient or Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Crabapple Integrative & Internal Medicine

## Administrative Services and Fees

The Administrative services listed below are offered to our patients and are not covered by your insurance.

- 1) Disability Letter for established patients only - \$250.00
- 2) Completion of all forms including life insurance forms and other miscellaneous forms required by third parties other than insurance companies - \$25.00
- 3) Patient requested additional claims, statements, payment histories, and prescriptions etc. - \$15.00

All of these services add to the cost of caring for our patients. Still, we are committed to providing you the best possible care at the lowest possible cost. We look forward to a lasting and healthy relationship and we thank you for your understanding and cooperation.

\* Note: for simple requests such as a copy of a recent Treatment Plan or a recent laboratory result, you will not be charged the above mentioned fee.

***I understand the services and fees listed above and agree to pay for them, as needed.***

**Patient Name:** \_\_\_\_\_

**Patient or Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_