Wholesome Family Medicine

4036 S. 6th St. Ste. #2 Klamath Falls, OR 97603
Phone: (541) 851-9320 Fax: (541) 851-9322

Adult New Patient Intake

Name: _____
Last *First* *M.I.*

Date of Birth: _____ **Age**: _____ **Gender**: **F** **M** _____

Marital Status: Married Single Divorced Domestic Partnership

Name and address of Dr's office/hospital/clinic where your records are kept:

_____
Office/Hospital/Clinic Name *Street/ P.O. Box*

_____
City *State* *Zip Code*

Contact Information:

Address: _____

City:_____ **State:** _____**Zip Code:**_____

Telephone: Please circle the preferred number to contact you:

Home #:_____Work #:_____Cell #:_____
Ok to text? Y N

E-mail:_____

Emergency Contact: _____Phone:_____

Relation: _____
__

Insurance Provider: _____

Verification of Naturopathic Coverage?:_____

Preferred pharmacy: _____

How did you hear about Wholesome Family Medicine?: _____

ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your top four health goals?

1) _____ 3) _____

2) _____ 4) _____

MEDICATIONS

Do you have any drug allergies? If yes, please list drug along with reaction: _____

_____

Please list all medications and supplements (with doses) currently being taken. Please bring all bottles with you to your appointment.

_____

_____

_____

_____

_____

MEDICAL HISTORY

Please list all medical diagnoses with initial dates below:

Condition: _____ **Date:**_____

Condition: _____ **Date:**_____

Condition: _____ **Date:**_____

Condition: _____ **Date:**_____

Condition: _____ **Date:**_____

Additional: _____

Imaging and Special Studies

	When	Where	Results
X-ray:			
MRI:			
CT Scan:			
Other:			

INJURIES/SURGERIES/HOSPITALIZATIONS

_____

_____

_____

IMMUNIZATIONS

Any adverse reactions to immunizations? (Please specify)

_____

_____

DIET

Do you have any food intolerances that you know of? Yes _____ No _____
If yes, please explain: _____

_____

SYMPTOMS

Please circle: Y=current condition N=never had P=had in the past

Skin issue	*Y P N*	*Gas/bloating*	*Y P N*	*Bloody urine*	*Y P N*
Infection	*Y P N*	*Heartburn*	*Y P N*	*Anxiety*	*Y P N*
Bleeding gums	*Y P N*	*Belching*	*Y P N*	*Depression*	*Y P N*
Nose bleeds	*Y P N*	*Nausea/Vomiting*	*Y P N*	*Sleep problems*	*Y P N*
Headaches	*Y P N*	*Anemia*	*Y P N*	*Night sweats*	*Y P N*
Dizziness	*Y P N*	*Urinary issues*	*Y P N*	*Sensitive to light*	*Y P N*
Change in vision	*Y P N*	*Libido issues*	*Y P N*	*Body/Breath odor*	*Y P N*
Hearing loss	*Y P N*	*Easy bruising*	*Y P N*	*Sinus infections*	*Y P N*
Sore throat	*Y P N*	*Flat feet*	*Y P N*	*No appetite*	*Y P N*
Runny nose	*Y P N*	*Back pain*	*Y P N*	*Nightmares*	*Y P N*
Trouble swallowing	*Y P N*	*Canker sores*	*Y P N*	*Wheezing*	*Y P N*
Stomach pain	*Y P N*	*Cough*	*Y P N*	*Fever*	*Y P N*
Diarrhea	*Y P N*	*Unintended weight loss*	*Y P N*	*Frequent colds*	*Y P N*
Constipation	*Y P N*	*Bleeding tendency*	*Y P N*	*Excessive fatigue*	*Y P N*

Do you have any other condition not mentioned? _____

_____

FAMILY HISTORY (Y or N)

____Heart Disease ____Diabetes ____Birth defect ____Cancer ____Mental Illness
____Hypertension ____Arthritis ____Tuberculosis ____Allergies ____Hay fever
____Eczema ____Other (please explain)_____
_____

Women:

Age of first menses: _____ Cycle length (days): _____ PMS?: _____
Date of last Pap: _____ Any history of abnormal Pap results?: _____
Any concerning symptoms with menses?: _____
Hysterectomy? ___ Complete/Partial?_____ Year: _____ Reason:_____

Is there anything else relevant to your health that you feel would be helpful to share?:

Wholesome FAMILY MEDICINE
Naturopathic Primary Care for the Whole Family

•Laura Blevins, ND Crystal Yarnall, FNP•4036 S. 6th St. Ste.#2 Klamath Falls, OR 97603 •
Phone: (541) 851-9320 •Fax: (541) 851-9322

No Show Policy

We strive to provide the best service possible to our patients. When someone doesn't show up for an appointment it provides a major inconvenience not only to our providers and staff, but also harms other patients who may be waiting for cancellations to get an earlier appointment. **Please** be respectful and always call at least 24 hours before your appointment if you need to reschedule. By signing the authorization below, you indicate understanding that **should you no-show a new patient appointment** you may be prevented from scheduling **AT ALL** in the future. Established patients may be charged up to $50 for no-showing follow-up visits. Cancellations made less than 24 hours in advance, should an emergency situation occur, are subject to provider review for reason to determine whether a fee will be charged.

Patient Name (Printed): _____

Date: _____

Patient/Parent/Guardian signature:

_____

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Medical Records Request Form

By signing this form, I authorize release of confidential health information about me, by releasing a copy of my medical records, or a summary/narrative of my protected health information, to the clinic/practitioner listed above.

HIV/AIDS: I consent to the release of any positive/negative test result for AIDS/HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records: Initial: _____ Date: _____

Limitations on the information to be released subject to this form are as follows:

_____

I grant permission to release my protected health information from the following provider:

Name: _____

Address: _____

Phone: _____

Fax: _____

_____ _____

Patient Signature (or parent/guardian/legal representative) Today's Date

_____ _____

Printed Name Date of Birth

This form will be considered valid for 90 days from date of signing unless authorization is revoked by patient in writing.

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Financial Agreement Policy

Patient Name:_____

Patient DOB:_____

Thank you for choosing Wholesome Family Medicine for your family's medical care. We are committed to providing you with quality personal healthcare. As a part of our professional relationship, it is important you have an understanding of our financial policy. Other than for true medical emergencies, agreement with this policy is required for all medical care.

Payments Co-Payments Policy

- All co-payments, current balances are due and payable Prior to services being rendered and is required by your insurance to be paid at each visit. Patients who do not have their copayment may have their appointment rescheduled.
- Deductibles and co-insurance are due and payable at checkout after services provided on the day of service.
- If you do not know your co-pay we may collect a minimum fee of $30.00. Our billing department will bill or credit your account accordingly after your insurance pays their portion.

Cancellation/No Show Policy

- While understanding that there may be times when you miss an appointment due to emergencies or obligations, our office requires at least 24 hours prior notice on all cancelled appointments to avoid a $50 no-show fee ($200 for new patient visits).
- New prescriptions will not be issued without seeing your provider
- Refill prescriptions may require an office visit or labs before further prescriptions are authorized.

Form Completion Policy

- All forms requiring physician signature and medical review- i.e., school, daycare, camp physicals; prior authorizations; FMLA; disability or other paperwork- will be assessed and may be charged a $25 fee or require a visit. Patient is responsible for payment.

Return Check Policy

- There is a $35 charge for returned checks added to your original balance. In addition, we may seek all additional legal remedies provided to us under Oregon law.

Patient Balance Policy

- Wholesome Family Medicine, after filing with insurance companies will mail you a Patient Balance Statement. Payment in full is due upon receipt of this statement. If you have any questions or dispute the balance it is your responsibility to contact the billing office within 30 days. Past due accounts will be subject to a 9% monthly late fee (minimum of $5 per month) and may be referred to a collection agency.
- If you are not able to pay your balance in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements.
- Any balances which are sent to collections will automatically incur a $75 fee in addition to monies owed.

Insurance

1. Bring your valid and up-to-date proof of insurance coverage and a valid ID to each appointment.
2. Complete patient information form as needed at each appointment.
3. Notify our office of any changes to your insurance.
4. Be familiar with your co-pay, benefits, and be prepared to pay co-pay at each visit.
5. Determine if office/physicians are network providers prior to your visit.
6. It is your responsibility to know coverage of your particular plan. Although we are happy to check benefits there is never a guarantee of payment. We participate in most managed care plans and will file your insurance plan as may be necessary; however, patients are required to pay for their portion of their health plan benefits at the time services are provided.

Thank you for understanding our payment policy. Please let us know if you have any concerns. I have read and understand the Financial Policy Agreement and agree to abide by its guidelines.

Patient signature: _____ Date: _____

If applicable, Legal Representatives sign below:

_____ Date:_____

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof if requested (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.