RejuveNature Medical

7747 W. Deer Valley Rd. Ste 235 Peoria, AZ 85382
(623) 487-0002

CONFIDENTIAL PATIENT INFORMATION
PLEASE FILL IN ALL PORTIONS OF THIS FORM
PLEASE ASK IF YOU NEED HELP

Name of Patient _____ e-mail _____
Permanent Address _____
City _____ State _____ Zip _____
Temporary Address _____ What dates? _____
City_____ State_____ Zip _____
Date of Birth _____ Age _____Marital Status (circle) S M P D
Phone (Home) _____ (Cell)_____
(Work) _____ May we leave messages? (circle) Y N
(Fax) _____ SS# _____
Employed by _____ Occupation _____
Name of spouse (or parent if minor) _____
Work Phone _____ SS# _____
Employed by _____ Occupation _____
Name of relative not living with you _____
Whom may we contact in case of emergency? _____
Phone _____

How did you hear about us? Yellow pages _____ Newspaper _____ Supermarket _____
Location/Sign _____ Internet _____ Other (list) _____
Referred by _____
I have indicated below all the appropriate means to contact me (please initial):

_____ Email _____ Cell Phone _____ Home Phone _____ Work Phone

CLINIC POLICY REQUIRES PAYMENT AT TIME OF SERVICES

TODAY's PAYMENT WILL BE BY:

CASH _____ CHECK _____ VISA _____ MC _____AMEX _____ DISCOVER _____

At time of payment, I will be given a copy of my superbill from our office. This will show diagnosis, services and charges. I can submit this form for reimbursement directly to my insurance company. (Please let the front office know if you plan to submit your bill to your insurance. This will enable us to give you the appropriate information.)

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish any additional medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable. Further more, any charges, fees or court costs incurred as a result of collection efforts will be added to my account balance.

Releases may be requested prior to specific procedures being performed (i.e. minor surgery, etc.)

_____ _____
Patient Signature Date

_____
Parent/Guardian Signature

Name _____Date: _____

1. **CIRCLE** current conditions. 2. **CHECK MARK** former conditions.
2. **STATE** duration, frequency, intensity and pain in the space beside current symptoms.

GENERAL SYMPTOMS

- ☐ Tremors
- ☐ Headache
- ☐ Fever
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Depression
- ☐ Loss of weight
- ☐ Forgetfulness
- ☐ Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees or feet
- ☐ Confusion
- ☐ Paralysis

EYES, EARS, NOSE AND THROAT

- ☐ Failing vision
- ☐ Near sightedness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cross eyed
- ☐ Eye inflammation
- ☐ Glaucoma
- ☐ Deafness
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Nasal drainage
- ☐ Loss of smell
- ☐ Sinus infection
- ☐ Hay fever
- ☐ Allergies
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Difficulty swallowing
- ☐ Loss of taste
- ☐ Change in tastes
- ☐ Dental decay
- ☐ Gum troubles
- ☐ Tonsillitis
- ☐ Asthma
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Enlarged glands

SKIN

- ☐ Skin eruptions
- ☐ Clammy skin
- ☐ Dryness
- ☐ Bruises easily
- ☐ Boils
- ☐ Rashes
- ☐ Sensitive skin
- ☐ Hives or allergy

RESPIRATORY

- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficult breathing
- ☐ Wheezing

CARDIO-VASCULAR

- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ Irregular beating heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Previous heart stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke
- ☐ Varicose veins

MUSCLE AND JOINT

- ☐ Stiff neck
- ☐ Pain between shoulders
- ☐ Backache
- ☐ Painful tailbone
- ☐ Foot trouble
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Swollen joints
- ☐ Stiff joints
- ☐ Painful joints
- ☐ Arthritis
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Sciatica

GENITOURINARY

- ☐ Frequent urination
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection or stones
- ☐ Bed-wetting
- ☐ Inability to control urine
- ☐ Prostate trouble
- ☐ Bladder trouble
- ☐ Foul smelling urine
- ☐ Discolored urine

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Belching or gas
- ☐ Nausea
- ☐ Gas
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over stomach
- ☐ Distention of abdomen
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stool
- ☐ Blood in stool
- ☐ Colon trouble
- ☐ Hemorrhoids (Piles)
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis
- ☐ Weight trouble

THIS SECTION FOR FEMALES ONLY

- ☐ Painful menstrual periods
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or backache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ Congested breast
- ☐ Breast pain
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Abnormal bleeding
- ☐ Reduced sexual energy
- ☐ Pregnancy
- ☐ Pregnancy complications

THIS SECTION FOR MALES ONLY

- ☐ Pain associated with genitals
- ☐ Reduced sexual energies
- ☐ Premature ejaculation
- ☐ Seminal emission
- ☐ Impotence
- ☐ Discharges

Name _____Date: _____

THIS SECTION FOR MALES ONLY:

Please check or explain if applicable:

☐ Reduced sexual energies _____
☐ Premature ejaculation _____
☐ Seminal emission _____
☐ Impotence _____
☐ Discharges _____
☐ Pain associated with genitals _____
☐ Other _____

THIS SECTION FOR FEMALES ONLY:

Are you or might you be pregnant? ☐ YES What month? _____ ☐ MAYBE ☐ NO
Do you use a method of birth control? ☐ YES Type: _____
Are you experiencing reduced sexual energies? ☐ YES ☐ NO Explain:
_____
_____
Other difficulties? ☐ YES ☐ NO Explain:
_____
How often do you have a PAP done? _____ Date of last PAP _____ Always Normal? _____
How often do you have a Mammogram? _____ Date of last Mammo _____ Always Normal? _____
How often do you have a DEXA? _____ Date of last DEXA _____ Always Normal? _____

Menstrual Cycle:

Age started: _____ Last menstrual period: _____ Age stopped: _____
Please check or explain if applicable:
☐ Irregular _____
☐ Painful _____
☐ Excess blood _____
☐ Lack of blood _____
☐ Dark _____
☐ Light _____
☐ Heavy clotting _____
☐ Water retention _____
☐ Painful breast _____

Vaginal Discharge:

☐ Liquid _____
☐ Yellow _____
☐ Thick _____
☐ Bad odor _____
☐ White _____
☐ Other _____

Gynecological History or Operations:

☐ Ovaries _____
☐ Uterus _____
☐ Tubes _____
☐ Vagina _____
☐ Breast _____
☐ Other _____

Pregnancy:

☐ Number of pregnancies: _____ ☐ Number of abortions: _____
☐ Number of children (including adoptees): _____ ☐ Number of miscarriages: _____
Explain complications: _____
_____

Name _____Date: _____

Do you now undertake (or have you ever undertaken) any kind of diet program? Please describe and indicate when:

_____

_____

CURRENT MEDICATIONS: (Do you take or use the following?)

Laxatives	☐ YES ☐ NO	Pain relievers	☐ YES ☐ NO	Antacids	☐ YES ☐ NO
Cortisone	☐ YES ☐ NO	Appetite suppressants	☐ YES ☐ NO	Sleeping pills	☐ YES ☐ NO
Tranquilizers	☐ YES ☐ NO	Thyroid medication	☐ YES ☐ NO		

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

NAME	DOSE	HOW YOU TAKE IT	START DATE	END DATE

List <u>ALLERGIES</u>: (Drugs, chemicals, foods) Please list type of reaction.

_____ _____

_____ _____

_____ _____

If not indicated previously, what types of acute illnesses do you get? How often have you experienced them in the past five years?

_____

_____

What is the most important health change you would like to occur?

_____

_____

_____

Name _____Date: _____

Please add any other information about yourself or your condition that might not have been previously mentioned:

_____

_____

_____

FAMILY HISTORY: (Please check all that apply to natural-born relatives.) Check _____ if adopted.

	Father	**Mother**	**Brothers**	**Sisters**	**Grandparents**	**Child(ren)**
Age (if living)	_____	_____	_____	_____	_____	_____
Health: G=good P=Poor	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma, Hayfever, Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

CHILDHOOD ILLNESSES: (Please circle Y = yes or N = no)

Scarlet fever Y N Diphtheria Y N Rheumatic fever Y N
Mumps Y N Measles Y N German Measles Y N
Other _____

HOSPITALIZATION AND SURGERY (Please list all surgeries and hospitalization you have had.)

X-RAYS AND SPECIAL STUDIES: (X-rays, CAT scans, MRI's, etc.)

Have you had an Electrocardiogram? ☐ YES ☐ NO
Have you had an Electroencephalogram? ☐ YES ☐ NO

IMMUNIZATIONS:

Polio ☐ YES ☐ NO
Tetanus shot (not antitoxin) ☐ YES ☐ NO
Measles/Mumps/Rubella ☐ YES ☐ NO
Pertussis ☐ YES ☐ NO
Diphtheria ☐ YES ☐ NO
Other _____

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I, _____, give permission to RejuveNature Medical to release any of my test results or medical information to any person(s) listed below:

NAME	**RELATIONSHIP**	**PHONE**
1.		
2.		
3.		
4.		
5.		

_____ _____
Signed Date

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PLEASE BE AWARE:

Rescheduled / Cancelled Appointments, and After-hour / Emergency Appointments:

The patient is ALWAYS responsible to call **24 hours prior to the scheduled appointment time** to reschedule or cancel. Failure to do so will result in a $ 85.00 charge to the patient for the missed appointment.

If you need to reach a doctor after regular business hours, there will be a $85 fee for the urgent phone call**.** If you have an emergency, please call 911.

NSF Check Fees:

NSF checks that are returned to us will cause an automatic charge to the patient account of $35. The patient will be responsible to pay the amount of the check in addition to the $35 NSF amount immediately.

Payment for Services and Insurance Reimbursement:

An insurance policy is a contract between you and your insurance company. The patient is ALWAYS responsible for payment of all charges incurred regardless of any insurance or other third party payment arrangements.

- Payment for all appointments, labs, procedures and supplements will be collected at the time of service.
- Any lab kits purchased are non-refundable after 30 days. Only unopened supplements are refundable.
- Some insurance companies and policies cover our Primary Care Practices and possibly Alternative Medical procedures in your Out-of-Network coverage. It is your responsibility to know your policy and submit directly.

Products available for Purchase:

The natural medicines that are prescribed by the clinics' practitioners may be purchased at this clinic or at another store of your choice. The products purchased at this clinic are Nutraceutical grade.

I certify that I have read and understand the above policies. I guarantee payment of all charges incurred as a patient of RejuveNature Medical.

Signed: _____

Parent or Guardian (if minor): _____

Date: _____

NOTICE OF PRIVACY PRACTICES
(For Patient Records)

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that my be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to RejuveNature Medical; 7747 W. Deer Valley Rd. Ste 235 Peoria, AZ 85382. Note: *We must respond to this request within 30 days.*

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to , RejuveNature Medical; 7747 W. Deer Valley Rd. Ste 235 Peoria, AZ 85382. You must provide us with a reason that supports your request for amendment.

Note: *We must respond within 60 days. The Privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Administrator at RejuveNature Medical; 7747 W. Deer Valley Rd. Ste 235 Peoria, AZ 85382. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Administrator at RejuveNature Medical.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of RejuveNature Medicals' Notice of Privacy Practices.

____ ____________________________

Patient or legally authorized individual signature Date

____ ____________________________

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

Revisions (if any):

____

____

____

____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify):

____

____

____