NATURAL Health Works

PERSONAL AND INSURANCE INFORMATION

Please write legibly.

Name _____

Last First Middle

Address _____

City _____ State_____ Zip Code _____

Home Phone # _____ Cell Phone # _____

Employer _____ Work Phone # _____

Email Address _____ Marital Status M D S W

Date of Birth _____/_____/_____ Primary Care Physician _____

Emergency Contact _____ Phone #_____

Related to a Motor Vehicle Accident: Yes _____ No _____ Date of Injury: _____

Related to a Workers Compensation: Yes _____ No _____ Date of Injury: _____

Primary Insurance _____

Policy # _____ Group # _____

Guarantor (who insurance is through) _____

Relation _____ Guarantor Date of birth_____/____/_____

Guarantor Address _____

City _____ State_____ Zip Code _____

Guarantor's Employer _____

Secondary Insurance _____

Policy # _____ Group # _____

Guarantor (who insurance is through) _____

Relation _____ Guarantor Date of birth_____/____/_____

Guarantor's Employer _____

NATURAL Health Works

Medical History

Date:_____

Patient Name:_____ Birth date_____
Last First Middle Initial

Occupation _____ How were you referred to us? _____

What are your primary health concerns? List them in order of importance.

_____

_____

_____

Past Medical History:

Major Illnesses:

_____

_____

_____

Accidents or major trauma (Scars – Please give location):

_____

_____

_____

Hospitalizations/Surgeries/ Major Dental Procedures:

_____

_____

_____

_____

Current Prescription Medications (names and doses):

_____

_____

_____

Allergies and Sensitivities: Foods, Environmental, etc…

_____

_____

_____

_____

_____

_____

Women: Last Pap_____ First day of last menstrual Period _____

Length of last period _____ # days between periods _____ regular cycle Yes / No
Age first Menstruation _____
No. of Pregnancies _____ Deliveries _____ Complications _____

Men: Last prostate exam_____ Results_____

Which diagnostic studies have you had in the past year?
☐ Electrocardiogram (EKG) ☐ X-Ray ☐ Bone Density Scan (DEXA) ☐ CT Scan
☐ Electroencephalogram (EEG) ☐ Mammogram ☐MRI ☐ Other: _____

Lifestyle Factors: Please indicate how often and how much.
Coffee / tea_____
Tobacco _____
Alcohol _____

Exercise Activities: Indicate type of exercise, How many minutes, and how often.

_____

_____

Health History: **Indicate Current (past 6 months), Past (greater than 6 months) and family history**

Condition	Current	Past	Family	Whom	Condition	Current	Past	Family	Whom
Alcoholism	__	__	__	_____	Hypertension	__	__	__	_____
Allergies	__	__	__	_____	Hypoglycemia	__	__	__	_____
Abdominal	__	__	__	_____	Hypothyroid	__	__	__	_____
Abdominal pain	__	__	__	_____	History of abuse	__	__	__	_____
Anxiety	__	__	__	_____	Indigestion	__	__	__	_____
Arthritis	__	__	__	_____	Insomnia	__	__	__	_____
Asthma	__	__	__	_____	Excess irritability	__	__	__	_____
Back pain	__	__	__	_____	Joint pain	__	__	__	_____
Bleeding Tendency	__	__	__	_____	Kidney Disease	__	__	__	_____
Bloating	__	__	__	_____	Liver Disease	__	__	__	_____
Breast problems	__	__	__	_____	Lupus	__	__	__	_____
Cancer	__	__	__	_____	Mental Illness	__	__	__	_____
Chrohn's Disease	__	__	__	_____	Migraines	__	__	__	_____
Constipation	__	__	__	_____	Multiple Sclerosis	__	__	__	____
Diarrhea	__	__	__	_____	Neck pain	__	__	__	_____
Depression	__	__	__	_____	Nightmares	__	__	__	_____
Diabetes	__	__	__	_____	Prostate problems	__	__	__	_____
Drug addiction	__	__	__	_____	Rheumatoid Arthritis	__	__	__	_____
Ear problems	__	__		_____	Seizures	__	__	__	_____
Epilepsy	__	__	__	_____	Skin Disease	__	__	__	_____
Eye problems	__	__	__	_____	Sinusitis	__	__	__	_____
Fatigue	__	__	__	_____	Sexual dysfunction	__	__	__	_____
Gall Bladder	__	__	__	_____	Thyroid Disease	__	__	__	_____
Glaucoma	__	__	__	_____	Tuberculosis	__	__	__	_____
Hearing Loss	__	__	__	_____	Urinary Problems	__	__	__	_____
H Heart Disease	__	__	__	_____	Other:_____	__	__	__	_____
High Cholesterol	__	__	__	_____	Other:_____	__	__	__	_____
Headache	__	__	__	_____	Other:_____	__	__	__	_____

Welcome to Natural Health Works, PC!

We are pleased that you have chosen us at Natural Health Works, PC. Our philosophy is to empower you to actively participate in your own healing. Our treatments use a holistic approach. It is important to us to know when you have ongoing health concerns, even when they are managed by another provider. Please keep us updated in any other health concerns you may be dealing with as well as any supplements and medications you may be taking. We believe that communication with our patients allows us to provide the best possible service to you. I authorize Natural Health Works, PC and their providers to treat me for medical conditions.

Insurance:

Physicians, patients and insurance carriers enter into a 3-way relationship to provide medical care. We assume the responsibility for providing high quality medical care and, according to our contracts; we file insurance claims on your behalf. Your insurance carrier has the responsibility to pay claims promptly and accurately without undue delay. We count on you to know your insurance benefits, provide us with accurate filing information, and to be attentive to making sure that your insurance carrier is paying claims in a timely manner. I authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to Natural Health Works, PC.

Our Policies: *Please initial each line*

1._____**Payments**: Co-payments, deductibles, supplements, and all non-covered services including select laboratory testing must be paid for at the time of service.

2._____**Insurance**: As a courtesy to you, we will file your insurance claims for you. Any Insurance filed and not paid within 90 days will be billed to the patient and payment will be expected from the responsible party.

3. _____**Private Pay:** Payment in full at time of service will be given a discount in coordination with allowed insurance contract rates. No discount will be given to payment plans. Payment plans requires 20% paid at time of service with remaining balance paid in equal payments over the next 3 months with a valid credit card left on file. I agree that NHW can charge my credit card on the agreed upon date.

4. _____ **Tardiness/Cancellations/Missed Appointments:** Please plan to arrive to your appointment on time. Our goal is to have your appointment start on time. Please call if you are running late. We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other clients that could benefit from this treatment time. There may be a $50.00 charge for patients cancelling without appropriate notice. A $50.00 fee may be charged for missed appointments without 24 hour notice. We may be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice, particularly if we feel that these appointments are adversely affecting your treatment plan. Prolotherapy Appointments must be cancelled 48 hours prior to the appointment; cancellations within 24 hours will be assessed a $50.00 charge; missed or late cancellations will be assessed at the rate of the entire visit. After two such cancellations in a six-month period it will be necessary to pay in advance for your appointment.

5. _____ **Privacy Policy:** I have been offered and/or received a copy of Natural Health Works, PC privacy policy.

If you have any questions regarding Natural Health Works, PC policies please contact a staff member. You may find us on the web at www.NaturalHW.com

I have read and agree to abide by the policies of Natural Health Works, PC

_____ _____

Responsible Party Date