CENTER FOR NATURAL FAMILY MEDICINE
HOMEOPATHY – PEDIATRICS – GYNECOLOGY –CHIROPRATIC – PHYSICALS FOR MEN/WOMEN
REGISTRATION FORM

(Please Print)

Today's date:	The patient is a child (minor) ________please check

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

I am parent /guardian ❑ Yes	Your Name:	Relation to Patient:	Patient's Birth date: / /	Age:	Sex: ❑ M ❑ F

Address:	Social Security no.:	Home phone no.: ( )

Email Address	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Who referred you? ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CENTER FOR NATURAL FAMILY MEDICINEhomeopathy – pediatrics – gynecology –chiropratic – physicals for men/women or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PERSONAL HEALTH HISTORY (all questions are strictly confidential)

WHAT IS THE REASON FOR YOUR VISIT?		
SURGERIES & HOSPITALIZATIONS		
Year	Reason	Hospital
CHILDHOOD ILLNESSES		
Age	Reason	

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUPPLEMENTS, HERBS, VITAMINS AND INHALERS	
Name:	
ALLERGIES TO MEDICATIONS	
Name:	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY			
Health Habits check which you use and how much	Caffeine	☐ Yes	☐ No
	Marijuana	☐ Yes	☐ No
	Tobacco	☐ Yes	☐ No
	Other (describe)	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	Do you use birth control? Method? (i.e. Pill, Condoms, IUD, Natural Fertility Planning)	☐ Yes	☐ No

FAMILY HEALTH HISTORY (Cancer, diabetes, heart, STD, alcohol/drug, tb, allergies, abuse, suicide, etc.)					
	AGE	SIGNIFICANT HEALTH PROBLEMS/DECEASED		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			**CHILDREN**		
MOTHER					
SIBLINGS			**GRAND-PARENTS**		

WOMEN ONLY			
Age at onset of menstruation::	Date of last menstruation:		
Are you pregnant or breastfeeding?		☐ Yes	☐ No
Date of last pap?	Was it normal/abnormal? Explain		

Do you have, or have you had, any of the following?

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

____

PATIENT CONSENT AND AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician(s) and it is the responsibility of the staff to carry out the instructions of the physicians.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to Lauren S. Feder, M.D. for any medical benefits that are applicable and otherwise payable to me, but shall not exceed the physician's regular charges. I specifically direct any second or third party to accept this assignment and pay the physician directly. I understand that I am financially responsible for charges that the insurance carrier declines to pay. In the case that a check is made payable to me or this office, for services rendered by this office, this document serves as a power of attorney for endorsement on my behalf.

LIEN: In the event that a lien is necessary to protect and ensure payment to Lauren S. Feder, M.D., this document serves, as notice of lien on any claim I may have and serves, as a power of attorney for signature on my behalf on such lien form should it be needed.

RELEASE OF INFORMATION: I authorize the release of information contained in my chart to relevant insurance companies, third parties & attorneys as may be needed to process and manage my case and claims.

REQUEST FOR INFORMATION: I authorize any custodian of records to release medical records and diagnostic studies (including X-Rays) to Lauren S. Feder, M.D. for the purposes of case management.

HMO DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of claims as a result of my enrollment in and HMO will constitute responsibility for payment of claim on my part.

MINOR'S RELEASE: If the patient is a minor, my signature as parent/guardian authorizes any needed diagnostic services and or treatment.

PREGNANCY: There is no reason to suspect that I might be pregnant at this time. If there is a possibility that I might be pregnant, I will advise the doctor prior to any X-Ray or onset of care.

Print Name: ______________________________ Date: ______________

Signature Patient (or Guardian) ______________________________

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent form.

1. The patient understands and agrees to allow Lauren S. Feder, M.D. to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing and further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient’s written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Print Name: ______________________________ Date: ______________

Signature Patient (or Guardian) ______________________________