PLENA INTEGRATIVE HEALTH CENTER

PATIENT REGISTRATION FORM

Legal Name:_____ **DOB:**_____/_____/_____ **Age:**_____
Preferred Pronouns:_____ **Preferred Name:**_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed **SSN:**_____-_____-_____
Address:_____
☐ **Home:**_____ ☐ **Cell:**_____ ☐ **Work:**_____ (***Check preferred)***
Email:_____
Employer:_____

May we text/email/leave voice reminders and messages? ☐YES ☐NO

May we retrieve prescription history when needed? ☐YES ☐NO **Preferred Pharmacy:**_____

Primary Insurance Company:
INSURANCE CO NAME_____
POLICY #_____ **GROUP #**_____
SUBSCRIBERS NAME_____ **SUBSCRIBERS DOB**_____/_____/_____
SUBSCRIBERS SSN:_____-_____-_____ **EFFECTIVE DATE OF COVERAGE**_____/_____/_____
SUBSCRIBERS ADDRESS:_____
SUBSCRIBERS EMPLOYER:_____
SUBSCRIBER' RELATIONSHIP TO YOU: ☐Self ☐Spouse ☐Parent ☐Other:_____

Secondary Insurance Company:
INSURANCE CO NAME_____
POLICY #_____ **GROUP #**_____
SUBSCRIBERS NAME_____ **SUBSCRIBERS DOB**_____/_____/_____
SUBSCRIBERS SSN:_____-_____-_____ **EFFECTIVE DATE OF COVERAGE**_____/_____/_____
SUBSCRIBERS ADDRESS:_____
SUBSCRIBERS EMPLOYER:_____
SUBSCRIBER' RELATIONSHIP TO YOU: ☐Self ☐Spouse ☐Parent ☐Other:_____

Responsible Party: *(if someone other than patient)*
Legal Name:_____ **DOB:**_____/_____/_____
Address:_____ **Apt #:**_____
City, State, Zip:_____ **Phone Number:**_____-_____-_____
Relationship to patient:_____

Emergency Contact:
Name:_____ **Relationship to patient:**_____
Phone Number:_____-_____-_____ **Address:**_____

PATIENT/LEGAL GUARDIAN SIGNATURE:_____ **DATE:**_____

Consent to Treat

I_____ *(patient name)* give permission for Plena Integrative Health Center to give me medical treatment. I understand that I have the right to refuse any procedure or treatment. I understand that I have the right to discuss all medical treatments with my provider. _____*(Initials)*

I allow Plena Integrative Health Center, or their appointed billing service, to file insurance claims on my behalf for the care I receive. I understand that in doing so, Plena Integrative Health Center will have to send my medical information to my insurance company. I also understand my insurance benefits are a contract between myself and my insurance company and that I am responsible for the cost of my care if my insurance does not pay in full or that I do not have insurance. _____*(Initials)*

I give Plena Integrative Health Center, or their appointed billing service, permission to contact me via email at _____ or leave a message at _____. _____*(Initials)*

I also consent to receive text messages/leave voicemails at_____. _____*(Initials)*

Signature:_____ **Date:**_____

Release of Information:

Patient health is confidential and private. The patient or legal representative must give permission to include others in discussion about their health. These discussions include things such as health history, explanations about the treatment or tests to be done, results of treatments or tests, discharge care needs, etc. Confidential information or discussions will not be shared with others without the patient's authorization. Persons the patient allows to enter the examination room will have implied authorization for the above. If you wish to include specific people in discussion of your healthcare and allow them to contact Plena Integrative Health Center on your behalf, please list them below:

Name:	**Relationship:**	**Phone Number:**
1.		
2.		
3.		

Signature:_____ **Date:**_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices that explains how my protected health information (PHI) will be used and disclosed. I understand that I am entitled to receive a copy of this document and authorize the use and distribution as described.

Signature:_____ **Date:**_____

HIPAA INFORMATION and CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, text message, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or healthcare provider.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Signature:_____ **Date:**_____

Reason for visit? _____
_____

Vitals *(for office staff only)*:

Height:_____ **Weight:**_____ **BP:**_____ **Temp:**_____

Allergies To Medications *(Please list below & include reaction)*

1._____
2._____
3._____
4._____
5._____
□ No Know Allergies

Current Medications *(Prescriptions and over-the-counter)*

Drug Name	Dosage	Physician	Drug Name	Dosage	Physician
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Gynecological History

Date of Last Menstrual Cycle:_____
At what age did you have your first period?_____
Current Birth Control:_____
Length of Menstrual Cycle?_____ days
Date of Last PAP Smear?_____/_____/_____
History of abnormal PAP smears? □ YES □ NO IF yes, when?_____
History of sexually transmitted infection? □YES □ NO IF yes, which STI?_____
Have you had the HPV Vaccine? □ COMPLETED □ NOT COMPLETED □ NO
Date of last Mammogram_____/_____/_____ Was it normal? □YES □ NO
Date of your last Colonoscopy _____/_____/_____ Was it normal? □YES □ NO
Date of your last Bone Density Test?_____/_____/_____ Was it normal? □YES □ NO
Have you gone through Menopause? □YES □ NO IF yes, what age?_____
Sexual orientation? □ Heterosexual □ Homosexual □ Bisexual □ Transgender □ Prefer not to disclose

Obstetrical History

Total # of pregnancies:_____ # of Full-Term Births:_____
# of Premature Births:_____ # of Abortions Induced:_____
# of Miscarriages:_____ # of Living Children:_____
# of Ectopic Pregnancies:_____ # of Multiple Births:_____

Surgical History: *(Please list any surgeries you have had)*

Surgery/Reason	**Hospital/Physician**	**Date of Surgery**
1.		
2.		
3.		
4.		
5.		
6.		

Family History: *(Please check if ANY blood relative(s) currently has or has had)*

Major Illnesses	**Yes/No**	**Which Blood Relative(s)?** *(Please include Maternal or Paternal)*	**Age at Onset**
Anemia	□YES □ NO		
Birth Defects	□YES □ NO		
Bladder Disease	□YES □ NO		
Kidney Disease/Stones	□YES □ NO		
Thyroid Problems	□YES □ NO		
Bleeding Disorder	□YES □ NO		
Breast Cancer	□YES □ NO		
Colon Cancer	□YES □ NO		
Cervical Cancer	□YES □ NO		
Ovarian Cancer	□YES □ NO		
Headache or Migraine (circle one)	□YES □ NO		
Epilepsy or Seizures	□YES □ NO		
Hepatitis	□YES □ NO		
Diabetes	□YES □ NO		
Angina/Heart Attack	□YES □ NO		
High Blood Pressure	□YES □ NO		
Heart Failure	□YES □ NO		
Stroke	□YES □ NO		

Family History: *Continued*

Lung Problems/Asthma	□YES □ NO		
Emphysema	□YES □ NO		
Liver Problems	□YES □ NO		
HIV/AIDS	□YES □ NO		
Alcoholism	□YES □ NO		
Tuberculosis-TB	□YES □ NO		
Venereal Disease/STD	□YES □ NO		
Sexual/verbal/physical abuse	□YES □ NO		
Other:			

Your Past Medical History:

Major Illnesses	**Yes/No**	**Major Illnesses**	**Yes/No**
Urinary Incontinence	□YES □ NO	Liver Problems/Hepatitis	□YES □ NO
Blood in Urine	□YES □ NO	Irritable Bowel Syndrome	□YES □ NO
Recurrent UTI	□YES □ NO	Gallbladder Disease	□YES □ NO
Kidney Stones/renal disease	□YES □ NO	Reflux/Ulcers	□YES □ NO
High Blood Pressure	□YES □ NO		□YES □ NO
Pre-Eclampsia	□YES □ NO	Vision Loss/Macular Degeneration	□YES □ NO
Heart Disease	□YES □ NO	Hearing Loss	□YES □ NO
Heart Arrhythmia	□YES □ NO	Acne	□YES □ NO
High Cholesterol	□YES □ NO	Eczema/Psoriasis	□YES □ NO
Thyroid Problems	□YES □ NO	Osteoporosis/Osteopenia	□YES □ NO
Prolactinoma	□YES □ NO	Arthritis	□YES □ NO
Diabetes / Gestational Diabetes	□YES □ NO	Fractures	□YES □ NO
Hemorrhoids	□YES □ NO	Vitamin Deficiency	□YES □ NO
Crohn's/Ulcerative Colitis	□YES □ NO	Bleeding Disorder	□YES □ NO
Colon Polyps	□YES □ NO	Endometriosis	□YES □ NO
Fibroids	□YES □ NO	Infertility	□YES □ NO

Your Past Medical History: *Continued*

Major Illnesses	Yes/No	Major Illnesses	Yes/No
PCOS	□YES □ NO	Chronic Back Pain	□YES □ NO
Dysplasia	□YES □ NO	Multiple Sclerosis	□YES □ NO
Blood Transfusion	□YES □ NO	Cancer	□YES □ NO
Anemia	□YES □ NO	Ovarian/ Endometrial/Cervical Cancer	□YES □ NO
Blood Clotting Disorder	□YES □ NO	Seasonal Allergies	□YES □ NO
DVT/Pulmonary Embolism	□YES □ NO	COPD/Emphysema	□YES □ NO
Stroke	□YES □ NO	Asthma	□YES □ NO
Aneurysm	□YES □ NO	Chicken Pox/Shingles	□YES □ NO
Sleep Apnea	□YES □ NO	Herpes	□YES □ NO
Migraines	□YES □ NO	MRSA	□YES □ NO
Headaches	□YES □ NO	Hepatitis A or B	□YES □ NO
Epilepsy/Seizures	□YES □ NO	Tuberculosis-TB	□YES □ NO
Anxiety	□YES □ NO	HIV/AIDS	□YES □ NO
Depression	□YES □ NO		□YES □ NO
ADD / ADHD	□YES □ NO		□YES □ NO
Bipolar Disorder	□YES □ NO	Other:	
Autoimmune Disease	□YES □ NO		

Your Social History:

What is your relationship status?_____
How old are you?_____
Are you sexually active? □ YES □ NO
What is your ethnic background?_____
What is the highest level of education you have completed?_____
Do you have an advance directive? □ YES □ NO
Is blood transfusion acceptable in the event of an emergency? □ YES □ NO
What is your exercise level? □ None □ Occasional □ Moderate □ Heavy
How many times a week do you exercise?□1-2 □ 3-4 □ 5-7

Do you or have you ever smoked tobacco?
□ Never Smoker □ Former Smoker □ Current everyday smoker □ Current some days smoker
If yes, how many packs per day?_____ Number of years?_____
Are you interested in quitting? □ YES □ NO

Your Social History: *Continued*

Do you consume alcohol? □ YES □ NO
If yes, how often? _____drinks per day _____drinks per week

Illicit or recreational drug use? □ YES □ NO
If yes, what substance and how often?_____

Do you have a history of domestic violence? □ YES □ NO
If yes, check all that apply □ Physical □ Emotional □ Sexual
Are you safe in your home now? □ YES □ NO