PLENA
Integrative Health Center
Compassionate Care for Mind, Body, & Soul

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PATIENT REGISTRATION FORM

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

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:**_____

Patient Name:_____ **Date of Birth:**_____

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:**_____

Patient Name:_____ **Date of Birth:**_____

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:**_____

Patient Name:_____ **Date of Birth:**_____

Health History

Preferred Name	Preferred pronouns	Age:
Referred by	Primary Care Provider	
What brings you to our office today?		
Office Use Only		
Weight:	Height:	BP:
Pharmacy		

Allergies (list medications, foods, latex)

Allergen	Reaction

Your Current Medications (please include hormones, vitamins, supplements, non-prescription medications)

Name & Dose	How often?	For what reason?	Who prescribed it?

Patient Name:_____ **Date of Birth:**_____

Current Symptoms

Are you currently having …		Describe
General		
Fever	Yes □ No □	
Chills	Yes □ No □	
Weight change (gain or loss)	Yes □ No □	
Head		
Headaches	Yes □ No □	
Migraines	Yes □ No □	
Breast		
Breast lump	Yes □ No □	
Breast tenderness	Yes □ No □	
Nipple discharge	Yes □ No □	
Chest		
Cough	Yes □ No □	
Difficulty breathing	Yes □ No □	
Heart		
High blood pressure	Yes □ No □	
Chest pain	Yes □ No □	
Irregular Heart Beat	Yes □ No □	
Gastrointestinal		
Abdominal pain	Yes □ No □	
Nausea	Yes □ No □	
Constipation	Yes □ No □	
Diarrhea	Yes □ No □	
Genitourinary		
Painful urination	Yes □ No □	
Leaking urine	Yes □ No □	
Gynecological		
Postmenopausal vaginal bleeding	Yes □ No □	
Vaginal odor/itching	Yes □ No □	
Vaginal dryness	Yes □ No □	
Vaginal / Vulvar pain	Yes □ No □	
Pain with intercourse	Yes □ No □	
Painful and/or periods	Yes □ No □	
PMS symptoms	Yes □ No □	
Musculoskeletal & Skin		
Joint pain/swelling	Yes □ No □	
Muscle pain	Yes □ No □	
Rash	Yes □ No □	
Psychiatric		
Mood changes (anxiety, depression)	Yes □ No □	
Hematologic/Endocrine		
Heat/Cold intolerance	Yes □ No □	
Easy Bruising	Yes □ No □	

Patient Name:_____ **Date of Birth:**_____

Gynecological & Preventative Health History

Date last period started:
At what age did you start your first period?
How far apart are your periods?
How many days do you have your period?
Do you want to get pregnant? Yes □ No □ If not, what are you using for birth control?
Have you had a sexually transmitted disease? Yes □ No □
Have you ever had a pap smear? Yes □ No □ Date: Results:
Any history of abnormal pap smears? Yes □ No □ Any treatment?
Have you had a mammogram? Yes □ No □ Date: Results:
Have you had a colonoscopy? Yes □ No □ Cologuard? Yes □ No □ Date: Results:
Have you had a bone density test? Yes □ No □ Date: Results:
Have you ever had a blood transfusion? Yes □ No □
Do you have an advance directive or living will? Yes □ No □

Pregnancy History

Total # of pregnancies	# miscarriages
# full term births	# ectopics
# premature births	# induced abortions
# living children	# multiple births
Please list any complications	

Surgical History (include LEEP, cesareans, D&C, etc)

Surgery	Date	Why?	Details

Patient Name:_____ **Date of Birth:**_____

History or Current Health History

Any history or current:			Details
Abuse (sexual, physical, emotional)	Yes □	No □	
ADD/ADHD	Yes □	No □	
Allergies, seasonal	Yes □	No □	
Anxiety	Yes □	No □	
Asthma	Yes □	No □	
Autoimmune disease	Yes □	No □	
Bleeding disorder	Yes □	No □	
Blood clotting disorder	Yes □	No □	
Cancer	Yes □	No □	
Crohn's or Ulcerative Colitis	Yes □	No □	
Chronic Back Pain	Yes □	No □	
COPD/Emphysema	Yes □	No □	
Diabetes /Hx Gestational Diabetes	Yes □	No □	
Depression	Yes □	No □	
Gallbladder disease	Yes □	No □	
Headaches/Migraines	Yes □	No □	
Heart Disease/ Heart Attack	Yes □	No □	
Hemorrhoids	Yes □	No □	
Hepatitis	Yes □	No □	
High Blood Pressure	Yes □	No □	
High Cholesterol	Yes □	No □	
Infertility	Yes □	No □	
Kidney Disorder (stones, infections, etc)	Yes □	No □	
Injuries (broken bones, etc)	Yes □	No □	
Liver Problems (hepatitis, fatty liver)	Yes □	No □	
Mental Health Diagnosis (bipolar, etc)	Yes □	No □	
Multiple Sclerosis	Yes □	No □	
Ovarian cysts	Yes □	No □	
PCOS (polycystic ovarian syndrome)	Yes □	No □	
Seizure disorder	Yes □	No □	
Skin conditions (eczema, acne, psoriasis)	Yes □	No □	
Stroke/ Deep Vein Thrombosis (DVT)	Yes □	No □	
Stomach issues (GERD, hernias, ulcers, IBS)	Yes □	No □	
Thyroid disease	Yes □	No □	
Urinary Tract Infections (frequent)	Yes □	No □	
Uterine problems (fibroids, polyps, endometriosis)	Yes □	No □	
Other medical issue not listed above			

Patient Name:_____ **Date of Birth:**_____

Family History

I don't know my family history. □		
Mother: Living? □ If deceased, age? Cause:		
Father: Living? □ If deceased, age? Cause:		
Siblings: How many total? _____ How many are alive? How many died? _____ If deceased, age (s)? Cause(s):		
Illnesses		Details
Cancer – Breast	Yes □ No □	
Cancer – Colon	Yes □ No □	
Cancer – Ovary	Yes □ No □	
Cancer – Uterus	Yes □ No □	
Mood disorder	Yes □ No □	
Diabetes	Yes □ No □	
Heart Disease (heart attack)	Yes □ No □	
High Cholesterol	Yes □ No □	
High Blood Pressure	Yes □ No □	
Stroke or Blood Clots	Yes □ No □	
Alcohol or drug abuse	Yes □ No □	
Thyroid disease	Yes □ No □	
Osteoporosis	Yes □ No □	

Social History

Marital Status:	
Sexual History: Never sexually active □ Not currently sexually active □ Currently sexually active with: Sexual orientation: Gender Identity:	
Race:	Language(s) spoken:
Religious affiliation:	
Highest level of schooling:	Current job:
Nutrition:	
Exercise:	

In the past month, have you consumed any alcohol? - How many **days per month do you drink? _____** - How many **drinks on any given day? _____** - How often did you have **4 or more drinks per day in the last month** _____	Yes □ No □

Patient Name:_____ **Date of Birth:**_____

Have you **smoked any cigarettes** in the past 3 months? If yes, list cigarettes per day ____	Yes □ No □
Do your **friends have a problem with alcohol or other drug use**?	Yes □ No □
Does your **partner have a problem with alcohol or other drug use**?	Yes □ No □
Are you **feeling at all unsafe in any way** in your relationship with your current partner or at home?	Yes □ No □
In the past, have you been in an **abusive domestic relationship?**	Yes □ No □
Over the last few weeks, **has worry, anxiety, depression or sadness** made it difficult for you to do your work, get along with people, or take care of things at home?	Yes □ No □
In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	Yes □ No □

Immunizations/Screenings

	Yes	Date	No		Yes	Date	No
TDAP				Flu Shot			
Hepatitis A				Pneumococcal			
Hepatitis B				MMR			
Varicella				TB Test			
Gardasil				COVID vaccine			
Shingles				Type:			

Any additional information that we need to know to better take care of you:

Forms completed by Patient □ Nurse □ Provider □ Other □	
Patient Signature:	Reviewed by: