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New Patient Admittance Form

Confidential Patient Information Date: _____

First Name: _____ MI: _____ Last: _____

Minor's Parent/Guardian Name: _____

Patient DOB: _____ Referred By: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Primary Address

Street: _____ Unit: _____

City: _____ State: _____ Zip: _____

Secondary Address ☐ Shipping ☐ Snowbird

Street: _____ Unit: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐ Married ☐ Single ☐ Other

Emergency Contact Information

Name: _____ Phone: _____

Email: _____ Relationship: _____

Insurance Information: ☐ NONE – Cash Patient ☐ Auto Accident* ☐ Work Injury*

*Supplemental information required. Please request forms.

Primary Insurance Company: _____

Name of Insured: ☐ Self ☐ Other: _____ DOB: _____

Employer: ☐ NA _____

Identification Number: _____ Group #: _____

Secondary Insurance Company: _____

Name of Insured: ☐ Self ☐ Other: _____ DOB: _____

Employer: ☐ NA _____

Identification Number: _____ Group #: _____

Patient Current Condition(s)/Concern(s)

Please list any current symptom(s) you may have in order of importance

1. _____
2. _____
3. _____
4. _____
5. _____

Patient History

Are you seeing anyone else for other problems or health conditions? ☐ No ☐ Yes

Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

	Problem/Condition	Date Began	Provider Seen
1.			
2.			
3.			
4.			
5.			

Past Health History

Are you seeing anyone else for other problems or health conditions? ☐ No ☐ Yes

Have you been:	No	Yes	Date Seen	Provider Seen
1. Hospitalized in the last 5 years?	☐	☐		
2. Diagnosed with Diabetes?	☐	☐		
☐ Type I ☐ Type II				
3. Treated for hypertension?	☐	☐		

Do you smoke or use tobacco products? ☐ Never ☐ Former ☐ Current Frequency: _____

Do you consume alcohol? ☐ Never ☐ Former ☐ Current Frequency: _____

	Surgery(s)	Year
1.		
2.		
3.		
4.		
5.		

	Serious illnesses and/or accidents with cause	Year
1.		
2.		
3.		

Do you have allergies – food, environmental and/or medication(s)? ☐ No ☐ Yes

	Type of Allergy	Reaction
1.		
2.		
3.		
4.		
5.		

Do you eat a special diet? ☐ No ☐ Yes

If yes, please describe: _____

_____

Please list chemicals, metals, dust or fumes you are repeatedly exposed to, or which you were repeatedly exposed to in the past:

Name of chemicals, metals, dust or fumes	Dates of Exposure
1. _____	_____
2. _____	_____
3. _____	_____

How many hours do you:

Work/Week: _____

Sleep/Night: _____ Quality of Sleep: _____

Exercise/Week: _____ Type of Exercise: _____

Do you use a contraceptive? ☐ No ☐ Yes Type: _____

Have you or any biological family member(s) had any of the following?

Self	Family	Condition	Self	Family	Condition	Self	Family	Condition	Self	Family	Condition
☐	☐	Allergies	☐	☐	Cancer	☐	☐	Hearing Loss	☐	☐	Macular Degeneration
☐	☐	Alcoholism	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Nervous/Mental Disorder
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Hypoglycemia	☐	☐	Tuberculosis
☐	☐	Bleeding Tendency	☐	☐	Heart Disease	☐	☐	Kidney Disease	☐	☐	Other: _____

Have you ever had any of the following?

Self	Condition	Self	Condition	Self	Condition	Self	Condition
☐	Back Trouble	☐	Fractures	☐	Hot Flashes	☐	Thyroid Disorder
☐	Blood Disorder	☐	Gall Bladder Disorder	☐	Liver Disorder	☐	Trouble with Sleep
☐	Cataracts	☐	Hepatitis C	☐	Loss of Sex Drive	☐	Ulcers, Peptic
☐	Car Accident(s)	☐	HIV	☐	Stroke	☐	Other: _____

What stress-reducing activities do you do regularly? _____

Are you willing to change your living habits to improve your health? ☐ No ☐ Yes

For Women

Date of last PAP: _____ Date of last Mammogram: _____ Date of last menstrual cycle: _____

Duration of cycle: _____ Number of children: _____ Ages: _____

Pregnancies:

Deliveries: _____ Complications: _____

Miscarriages: _____ Complications: _____

Abortions: _____ Complications: _____

Medications

What medications are you currently taking? Include vitamins, herbs, minerals and other over-the-counter remedies.

Please be as specific as possible, listing the Date Started, Brand or Generic Name, Strength, Dosage, Frequency, Duration, Quantity, # of Refills Available, and Prescribing Physician.

Date Started	Medication	Strength	Dosage	Frequency	Duration	Quantity	# Refills	Prescribing Physician

Other medications taken over the last 5 years

Date Started	Medication	Strength	Dosage	Frequency	Duration	Quantity	# Refills	Prescribing Physician

I authorize the doctors and staff at Narrows Natural Health Clinic to examine and treat my condition(s), which may include diagnostic testing deemed necessary for my care, medication(s) and/or therapy.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself, and that I am ultimately responsible for any and all expenses incurred at Narrows Natural Health Clinic.

Payment is expected at time of service unless otherwise negotiated in writing.
Past due accounts (60 days or more) are subject to 1% late fee.

Patient or Parent/Guardian Signature

Date