Northview Medical
7356 Stockman St, Cheyenne, WY 82009
Phone (307) 632-3399 Fax (307) 632-2050

Comprehensive Health History Form

Patient Information

Patient Name: _____
(last) (first) (middle initial)

Address: _____

City: _____ State _____ Zip _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Work Ph: (_____) _____ Best Contact: Phone Text Email

Email: _____ Sex: M or F

SS#:_____ DOB: _____ Age: _____

Status : □ Single □ Married □Widowed □Divorced □Separated □Minor

Occupation: _____

Employer: _____

In Case of Emergency

Name: _____ Relationship _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

How Did You Hear About Us?

□ Referral: _____ □ Direct Mail
□ Internet □ Magazine
□ TV □ Other: _____

What specific condition prompted you to choose us for your healthcare needs?

_____

_____

Insurance Information

Who is responsible for this account? □ Self □ Other:_____

If other, what is the relationship to patient: _____

Insurance Company: _____

Policy #:_____ Group #:_____

Is the patient covered by additional Insurance? □ Yes □ No

Subscribers Name:

_____

DOB:_____ SS#:_____

Relationship to Patient:

Primary Care

Primary Care Physician's Name _____

Clinic Name _____ Phone Number _____

I allow my health progression to be shared with my primary care physician:

□ Yes □ No

Do you have current X-rays at another office or clinic?

□ Yes □ No

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance, health plan, or medical benefits I have), I am ultimately responsible to pay Northview Medical Clinic, as well as all licensed professionals, employees, employers, representatives, and agents thereof; as well as all laboratories, pharmacies, clinics, hospitals, and equipment suppliers used by or referred by Northview Medical Clinic or by any of the forgoing (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, equipment, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. It is also my intention that Healthcare Provider shall possess any and all anti-retaliation protections that I may have under 29 U.S.C. § 1140 whenever Healthcare Provider is exercising my rights or acting on my behalf, or as my assignee, in anyway whatsoever.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing, and in such case, can only be revoked for future services, test, etc. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____ (SEAL)
(patient signature)

_____
(please print patient name)

X_____ (SEAL)
(signature of Guardian if applicable)

Current Medications

Medication **Dosage/How Long** **For What Condition?**

_____

_____

Medication Allergies: _____

Reaction?

_____

Supplement Allergies: _____

Reaction? _____

Food Allergies: _____

Reaction? _____

Do you have any surgical devices in your body? (*ie screws, pins, plates, etc)*

□ Yes □ No If yes, where located _____

Current Herbal Medications

Medication **Dosage/How Long** **For What Condition?**

_____

_____

_____

Other Medications

Please List Previous Medications (Last 10 Years)

Medication **Dosage/How Long** **For What Condition?**

_____

_____

_____

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No Describe: _____

_____

Have you had prolonged or regular use of:

NSAIDS (Advil, Aleve, etc.), Motrin or Aspirin? □ Yes □ No

Tylenol? □ Yes □ No

Acid Blocking Drugs (Tagament, Zantac, Prilosec)? □ Yes □ No

Frequent Antibiotics (> 3 times a year) □ Yes □ No

Long Term Antibiotics □ Yes □ No

Steroids Present or Past (Prednisone, Nasal Allergy Inhalers) □ Yes □ No

Current Condition

What do you hope to achieve in your visit with us?

_____

_____

When did the condition(s) begin?

_____

_____

Has it occurred before? □ Yes □ No When? _____

Is the condition getting worse? □ Yes □ No □ Unknown

Is the Condition: □ Auto Related □ Job Related □ Home Injury

□ Slip/Fall □ Lifting □ Slept Wrong □ Unknown Cause

□ Other _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation

What treatment have you received for your condition?

□ Medication □ Surgery □ Physical Therapy □ Chiropractic Services

□ None □ Other _____

Please list Current and Ongoing Problems in Order of Severity:

Problem _____

□ Mild □ Moderate □ Severe

Treatment/Approach _____

Success: □ Excellent □ Good □ Fair

Problem _____

□ Mild □ Moderate □ Severe

Treatment/Approach _____

Success: □ Excellent □ Good □ Fair

Medical History

Please check all that apply / Indicate When and any Comments/Results

Surgeries (Indicate what year and if applicable what region/area)

___ N/A	_____	___ Replacements	_____
___ Appendectomy	_____	___ Bunionectomy	_____
___ Cardiac Bypass	_____	___ Cataracts	_____
___ C-Section	_____	___ Carpal Tunnel	_____
___ Cosmetic	_____	___ Ear Tubes	_____
___ Gall Bladder	_____	___ Hysterectomy	_____
___ Implants	_____	___ Knee	_____
___ Lasik	_____	___ Spinal Fusion	_____
___ Tonsillectomy	_____	___ Wisdom Discectomy	_____

Family Health History

Check all family members that apply	Mother	Father	Brother (s)	Sister (s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (ex: Rheumatoid Psoriatic)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease (ex: Lupus, Hashimotos)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as Alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Other:												

NORTHVIEW MEDICAL CONSENT TO TREAT

I hereby request and consent to the performance of examinations, lab draws, and insertion of pellets or other procedures in relation to BioTe, where warranted, on me (or on the patient named below, for whom I am legally responsible for) by the practitioner named below and/or other licensed doctors who now or in the future work at the clinic or office listed below:

Amanda Tanner, CNM-APRN
Colby Vossler, PA

I have had an opportunity to discuss with the practitioners named the nature and purpose of procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine there are some risks to treatment

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely upon the practitioner to exercise judgment during the course of the procedure which the practitioner feels at the time, based upon the facts then known to him or her, is in my best interest. The practitioner named above has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____

Informed Consent for Conservative Care

To the patient: You have a right to be informed about your condition, the recommended treatment, and the potentiality of any risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

___I understand The Doctor and/or Medical Provider are offering to treat the pain and symptoms associated with the diagnoses of peripheral neuropathy, spinal disk herniations or bulge and subluxation with its associated neuromusculoskeletal conditions. The Doctor and/or Medical Provider will not offer to diagnose or treat any diseases.

___I understand that The Doctor and/or Medical Provider will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner.

___I understand that The Doctor and/or Medical Provider may be prescribing medications but will not be giving any advice about medications that I am currently taking. All medication advice is referred to your pharmacist and primary provider.

____ I understand that there are some risks to the insertion of pellets including, but not limited to: increased symptoms and pain, no improvement of symptoms or pain.

I have read, or have had read to me, the above consent. By signing below, I consent to the initial visit. I intend this consent form to cover the entire course of my treatment for my current condition.

To be completed by the patient:

_____ *Printed name*
_____ *Signature*
_____ *Date Signed*
_____ *Witness/Date*

To be completed by the Patient's representative:

_____ *Patient's Name*
_____ *Name of Representative*
_____ *Rep's Signature / Relationship*
_____ *Date Signed*