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?

_____

_____

Accident Information

Do you currently have an active accident claim? □ Yes □ No Date _____

Type of Accident: □ Auto □ Work □ Home □ Other _____

To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Work Comp □ Other _____

Attorney Name: (*if applicable)*

_____

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

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:

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

Lifestyle History

Check Your Exercise Levels:

□ **Inactive** □ **Light Activity** □ **Moderate Activity**

□ **Heavy Activity** □ **Vigorous Activity**

Please check all that apply:

□ Tobacco – Type _____ Amt/Day: _____

Are you exposed to 2nd hand smoke regularly? _____

□ Alcohol Drinks/Week: _____

□ Coffee/Caffeine Drinks Cups/Day: _____

Do you currently or have previously used recreational drugs? □ Yes □ No

If yes, what types/method (IV, inhaled, smoked, etc) _____

_____

Health History Please check all that apply (past or present) / Circle **CURRENT** Conditions

___ ADD
___ AIDS/HIV
___ Alcoholism
___ Allergies
___Alzheimer's
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Atopic Dermatitis
___ Bed Wetting
___ Bleeding Disorders
___ Blood Clot
___ Blood Transfusion
___ Breast Lump
___ Bronchitis
___ Bulimia
___ Cancer
___ Cataracts
___ Cerebral Palsy
___ Chemical Dependency
___ Chest Pain
___ Chicken Pox
___ Cholera
___ Chronic Fatigue Syndrome
___ Crohn's/Colitis
___ CRPS (RSD)
___ Constipation
___ CVA (Stroke)
___ Cystic Kidney Disease
___ Depression
___ Diabetes (*insulin*)
___ Diabetes *(non insulin*)
___ Ear Infections
___ Eating Disorder
___ Eczema
___ Emphysema
___ Epilepsy/Convulsions
___ Eye Problems
___ Fetal Drug Exposure
___ Fibromyalgia
___ Fractures
___ Gallbladder Disorder
___ Gallstones
___ German Measles
___ Glaucoma
___ Goiter
___ Gonorrhea
___ Gout
___ Headaches
___ Heart Attack
___ Heart Disease
___ Heart Failure
___ Hepatitis
___ Hernia
___ Herniated Disk
___ Herpes/Lesions/Shingles
___ High Blood Pressure
___ High Cholesterol
___ Hormone Replacement
___ Hypertension
___ Hypoglycemic
___ Influenza Pneumonia
___ IBS
___ Jaundice
___ Kidney Stones
___ Liver Disease
___ Lung Disease
___ Lupus Erythema (*Discoid*)
___ Lupus Erythema (Systemic)
___ Malaria
___ Measles
___ Migraine Headaches
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Nervous Breakdown
___ Osteoporosis
___ Pacemaker
___ Parkinson's disease
___ Pinched Nerve
___ Pleurisy
___ Pneumonia
___ Polio
___ Pregnancy
___ Prostate Problems
___ Prosthesis
___ Psoriasis
___ Psychiatric Care
___ Rheumatoid Arthritis
___ Rheumatic Fever
___ Scarlet Fever
___ Scoliosis
___ Seizure Disorder
___ Sickle Cell Anemia
___ Sinusitis
___ Sleep Apnea
___ Spina Bifida
___ STD
___ Stroke
___ Suicide Attempt(s)
___ Swelling Feet
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Tumors, Growths
___ Typhoid Fever
___ Ulcers
___ Vaginal Infections
___ Vertigo
___ Whooping Cough
___ Other:
_____
_____

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 _____

Injuries

___ Back Injury _____ ___ Broken Bones/Fractures _____
___ Head Injury _____ ___ Industrial _____
___ Neck Injury _____ ___ Severe Fall _____
___ Soft Tissue _____ ___ Other _____

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 IV cath or other procedures in relation to the infusion, 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*