MOUNTAIN VIEW NATURAL MEDICINE

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PEDIATRIC REGISTRATION FORM (7 – 17 YRS)

Name:_____Preferred name: _____ Date of Birth:_____

Family Ethnicity:_____Parent(s)/Legal Guardian(s)_____

Street Address:_____City/State/Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email Address:_____

May we leave a medically related message at home?_____ at work?_____ on cell?_____

What is your birth sex? Male_____ Female_____ Other (specify)_____

What gender do you identify as? Male____ Female____ Other (specify)_____

Pharmacy (include city):_____How would you like to receive appointment reminders: Email/Phone

Emergency Contact:_____ Phone:_____

GUARANTOR

Name:_____Street:_____

City/State/Zip:_____Phone:_____

INSURANCE INFORMATION

Insurance Company:_____Subscriber:_____

Address:_____Subscriber DOB:_____

Patient ID#:_____ Subscriber ID#:_____

Group #:_____ Patient's Relationship to Subscriber:_____

Subscriber's Employer/Address/Phone:_____

I authorize the release of any medical or other information necessary to process claims to my child's insurance carrier. I also request payment of government benefits either to myself or to the party who accepts assignment: Mountain View Natural Medicine. I authorize payment of medical benefits to Mountain View Natural Medicine for services rendered at this clinic and submitted to my child's insurance carrier.

_____

Signature Date

Relationship to Patient:_____

Would you like us to be your child's primary care provider? Y/N

Name of other PCP if applicable: _____

Please list your child's health concerns in order of priority along with other practitioners they may be seeing for the condition:
1. _____
2. _____
3. _____
4. _____

What do you believe is causing your child's most important health concerns?

Please list any medications and supplements your child is currently taking, along with doses and the reason they are taking them:

Medications:	Reason:	Date began:	Dose:

Supplements:	Reason:	Date began:	Dose:

**Please list any drug allergies: _____

**Please list any food allergies_____

**Please list any environmental allergies: _____

Parents/gaurdians often desire communication between their healthcare providers. Do we have your permission to communicate verbally and in writing with your son or daughter's other providers regarding their healthcare?

yes/no

PAST MEDICAL HISTORY: PLEASE LIST ANY MAJOR ILLNESSES:

Age or date:	Description:

CURRENT HEALTH CONCERNS (Review of Systems): Please check normal or abnormal and briefly explain.

N AbN

__ __ Constitutional (Energy, weight, body temperature, sleep, general sense of well-being) _____
_____
__ __ Head: headaches, vertigo, injuries etc.)_____
__ __ Vision/eye problems: _____
__ __ Ear/nose/throat/mouth (allergies, infections etc.)_____
__ __ Cardiovascular: (high BP, cholesterol etc.) _____
__ __ Respiratory_____
__ __ Digestive tract issues: (changes in bowel habits, hemorrhoids, bloating, pain, etc.) _____
_____
__ __ Musculoskeletal concerns (arthritis, joint problems, osteoporosis, muscle pain, weakness):_____
_____
__ __ Skin (eczema, infections, rashes, etc.) _____
__ __ Psychological (mood changes, sadness, irritability, anxiety etc.) _____
_____
__ __ Neurological (numbness, tingling, balance problems, memory etc.)_____
__ __ Hormonal issues (diabetes, thyroid problems, menopausal, adrenal etc.) _____
_____
__ __ Blood or lymph issues (current anemia, swollen glands etc.) _____
__ __ Allergies _____
__ __ Others:_____

FEMALE:

Onset of first menses was age___. Periods generally last ___ days and occur every ___ days.
Date of last period _____ Bleeding is __Heavy __Moderate __Light
Experiencing PMS symptoms?_____ List:_____
Experiencing any gynecological symptoms or problems?_____
_____
Currently sexually active?_____ Partner(s) is/are __Male __Female

MALE:

Currently sexually active?_____ Partner(s) is/are __Male __Female

GENERAL

Please fill in what you can:

	Recent	Past year	Past 5 years
Weight			
Height			

If tested in the past 2 years, please check:
_____Thyroid (normal? y/n) ____ Blood sugar (normal? y/n) ____Anemia (normal? y/n)
Date of last: Tetanus shot _____ Colonoscopy _____ (normal? y/n)

FAMILY HEALTH HISTORY: (be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)

Member	Living?/Age	Major illness or chronic conditions
Mother		
Father		
Siblings		
Mat. Grandmother		
Mat. Grandfather		
Pat. Grandmother		
Pat. Grandfather		

DIET: Please describe a typical day's diet for you, (be honest).

Breakfast	Lunch	Dinner	Snacks (what hour)

SOCIAL HISTORY: Please list sources and amounts of:
Caffeine:_____Alcohol:_____
Smoking history and amount:_____ Recreational drugs:_____

LIFESTYLE:
What is your exercise routine?_____

Do you wear seatbelts? Y/N. A bike helmet? Y/N

MENTAL HEALTH:
Over the **last 2 weeks**, how often have you been bothered by the following problems?:

Little interest or pleasure in doing things?

Not at all	Several days	More than half the days	Nearly daily
0	1	2	3

Feeling down, depressed or hopeless?

Not at all	Several days	More than half the days	Nearly daily
0	1	2	3

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Mountain View Natural Medicine has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact the **office manager at 802-860-3366**.

I also understand that I am entitled to receive updates upon request if Mountain View Natural Medicine amends or changes its Notice of Privacy Practices in a material way.

_____ _____

Signature | Relationship to Patient, if signed by someone other than patient.

_____ _____

Date | Patient's name if not signed by patient

THIS SECTION IS TO BE COMPLETED BY Mountain View Natural Medicine IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____ _____

Name and title of employee | Date

Financial Policy

PAYMENT IS EXPECTED WHEN YOU COME IN FOR AN APPOINTMENT

- Co-Payments, deductible, co-insurance and private pay fees, where applicable are due upon check out.
- Any deductible is due as soon as the amount can be determined
- You are responsible for understanding what your insurance plan will cover or not cover
- As a courtesy, we will bill non-participating insurance companies
- Postage and handling will be added to dispensary items. We will mail and require payment prior to mailing.

NOTIFY US OF ANY CHANGES IN YOUR ADDRESS AND/OR INSURANCE

- If your insurance changes, bring your new insurance card with you.
- Please contact your insurance company with insurance questions.

STATEMENTS ARE GENERATED FOR OUTSTANDING BALANCES

- If you are responsible for more than one patient account, we may offset an overpayment in one account to another account.
- We will assess a $25 service fee for any checks returned unpaid.
- If payment is not received within 21 days of the statement date your account will be considered delinquent

RETRUNED SUPPLEMENTS

- Any unopened item may be returned for a full refund within 30 days of purchase.
- Mail order items must be postmarked by 30 days of the original date of purchase. Return postage is nonrefundable.

WE USE COLLECTION AGENCIES FOR DELINQUENT ACCOUNTS

- If your account is delinquent, we may list your default with our credit reporting agency. If we incur any collection costs, these will be added to the balance you owe.

NOTIFY US TO CANCEL AN APPOINTEMNT

- If you need to cancel an appointment, please notify us 24 hours before the appointment.
- If you miss an appointment or are late in cancelling it, we may assess a $50.00 fee.
- If you frequently miss or cancel appointments, you may be discharged from the practice.

WE USE AND AUTOMATED SYSTEM FOR E-MAIL APPOINTEMNT REMINDERS

- An automated e-mail will be sent to the listed e-mail address prior to your appointment.
- Missed appointment fees apply regardless of whether a courtesy reminder was sent or not.

I've read the above financial policy of Mountain View Natural Medicine and agree to its terms. I am responsible for any balance due on my account or the patient I am responsible for.

Patient Name: _____
Responsibility party name: _____
Signature: _____ Date: ____/____/___