

## Center for Preventive Medicine

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www.PreventiveMedicineNH.com

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*Welcome to our office. We are happy that you have chosen to come to us for your complementary healthcare. Our Office policies are designed to assure that we are able to provide the quality of care you expect from us, and that all of our patients are able to receive their care promptly and with minimal waiting times. This letter explains our office policies. Please take a few minutes to read it, sign it and return it to our staff with your patient information forms. We look forward to meeting you.*

The undersigned acknowledges that he/she has requested healthcare services from the Center for Preventive Medicine. Many of the therapies offered at the Center are considered unconventional by mainstream medical establishment. Although some treatments have been in continuous use for a long period of time, they have been deemed "unproven" by such organizations as the American Medical Association, the Food and Drug Administration and certain insurance companies. Any therapy suggested to you can, of course, be refused and/or terminated at any time to receive only conventional therapies without the use of alternative or complementary modalities. Under no circumstance are you obligated to accept any treatment offered to you.

### **Disclosure of Information**

All information provided to the Center for Preventive Medicine staff and clinicians is strictly confidential except for the following circumstances:

- Your insurance company requests information about your treatment in order to process a claim or certify care.
- The patient authorizes the release of information by signing a release form naming the specific person to receive the information.
- Certain circumstances where we are required by law to release information (e.g. court subpoena, suspected abuse, etc.)

### **Financial Terms**

You are expected to pay for your care in full at the time services are rendered. We will provide you with a universal health insurance claim form so that you may submit a claim to your insurance company for reimbursement. We do not participate with any insurance companies, and do not submit insurance claims. If an amount owed by a patient is not received on a timely basis, the patient may be responsible for reasonable attorney fees and the cost of collection. There is a \$15 charge for copying medical records, and there is a \$25 fee for returned checks.

### **Canceled/Missed Appointments and Late Arrivals**

When you make an appointment, we are reserving time on a practitioner's schedule that is no longer available to other patients. We do require a \$100 deposit for all new patient appointments; which will be applied to the first visit. If you cannot make an appointment, we ask that you cancel your appointment at least 24 hours in advance. A new patient deposit will be refunded if you give 24 hours advance notice of cancellation. The Center's voice mail message center 603-673-7910 accepts messages about appointment cancellations at any time (24 hours/day). Missed appointments will result in a \$50 charge.

Late arrivals can create scheduling problems with other patients. If you must be late, please call to let us know. If you arrive more than 15 minutes late, we may not be able to accommodate your appointment without interfering with the scheduled times of the other patients.

### **Acknowledgement and Agreement**

I have read the above information and thoroughly acknowledge, understand, and agree to all of the above information, including the financial terms as stated above.

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Patient (or Parent/Guardian) PRINTED

Signature

Date



## Center for Preventive Medicine

### CURRENT MEDICATIONS/DIETARY SUPPLEMENTS

Please write the name, dosage and frequency of all current medications:

Name:	Dosage:	Frequency:

Vaccination History (What vaccine's if any and when?) **OR** Provide a copy of the original vaccination information, if possible.

### PRIMARY CARE PROVIDER/PEDIATRICIAN

Do you have a primary care provider? Yes/No If yes, please complete the information below:

Name and Address:	Office Phone: (     )
Has the child been seen by any other doctor(s) for this complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### HOSPITALIZATIONS AND SURGERIES

Date	Type or Reason

### CHILD'S TEST INFORMATION

Please specify when your tests were done if possible:

Current Height	feet	inches	Current Weight	pounds
Last physical exam			X-rays	
Hearing Tests			Vision Tests	
Speech Impediments			Learning Impediments	
Blood tests			Other tests	

### TYPICAL DAYS' DIET

Breakfast:	
Lunch:	
Dinner:	
Snacks:	

## Center for Preventive Medicine

### EXPOSURES

Any particular household stressors the child has witnessed or gone through? Please list:

1.	3.
2.	4.
Has the child ever lived near a refinery, polluted area or in a home with leaded paint? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to what sort of pollution were they exposed?	
Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	
Does the child seem particularly sensitive to perfumes, gasoline or other vapors? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you spray pesticides, herbicides or other chemicals around your home? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### CHILD'S ILLNESS HISTORY

YES indicates the child gets the problem **regularly**; NO indicates the child **never** had the problem; PAST indicates the child had the problem in the **past, but not recently**.

Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past	If yes, how many total:
Colds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past	If yes, how many total:
Strep Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past	If yes, how many total:

### CHILD'S HEALTH HISTORY

YES indicates the child gets the problem **regularly**; NO indicates the child **never** had the problem; PAST indicates the child had the problem in the **past, but not recently**.

Child Breastfed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long?	When was child put on formula?	Which formula?
When was child put on solid food?	When did child walk?	Talk?	Develop teeth?	
Jaundice as baby	<input type="checkbox"/> Yes <input type="checkbox"/> No	Colic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cradle Cap <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema or Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No
Nightmares	<input type="checkbox"/> Yes <input type="checkbox"/> No	Finicky Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bed-wetting <input type="checkbox"/> Yes <input type="checkbox"/> No
Poor Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tantrums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Sniffles <input type="checkbox"/> Yes <input type="checkbox"/> No
Disobedient	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bad Foot Odor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fears/Phobia <input type="checkbox"/> Yes <input type="checkbox"/> No
Very Sweaty Baby/Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diaper Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyperactivity <input type="checkbox"/> Yes <input type="checkbox"/> No
Early Puberty	<input type="checkbox"/> Yes <input type="checkbox"/> No	Growing Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Aches <input type="checkbox"/> Yes <input type="checkbox"/> No

### FAMILY HISTORY

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past	Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past	Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past	Cardiovascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past
Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past				

### MOTHER'S PREGNANCY HISTORY

Age at conception:			Did she have other children already? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coffee	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emotional Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No
Preeclampsia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Length of Labor	Vaginal Birth		<input type="checkbox"/> Yes <input type="checkbox"/> No
Traumatic Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No	If birth was difficult, please explain:			
Health of baby at birth:					