

# Patient Demographic Form

Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: M F (circle one) Marital Status: S M D W # Children \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

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Insured's Name: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ Insured's D.O.B. : \_\_\_/\_\_\_/\_\_\_

Insured's Address: \_\_\_\_\_ Patient's Relationship to Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Plan Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Group Name: \_\_\_\_\_ InsuranceType: PPO POS EPO HMO Traditional

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Emergency Contact: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Emergency Contact #: \_\_\_\_\_

How did you hear about our medical office? \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



**MARANATHA NATURAL LIVING, LLC**  
A PASSION FOR BETTER MEDICINE

Maranatha Natural Living, LLC  
1860 Weatherhead Hollow Rd.  
Guilford, VT 05301-9821  
Email: maranathaliving@gmail.com  
www.maranathaliving.com  
Gabiella Neacsu katz , FNP-BC



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Consent to Use Protected Health Information

For Treatment, Payment and Health Care Operations

I consent to allow Maranatha Natural Living, LLC to use or disclose my protected health information for treatment, payment and health care operations.

1. Treatment means the provision, coordination, or management of health care and related services by one or more health care providers
2. Payment means the activities undertaken by a health care provider or business associate or health care plan to obtain or provide reimbursement for the provision of health care, including the right to call the patient, leave messages on the answering machines and/or voicemail.
3. Health care operations means conducting quality assessment and improvement activities, reviewing the competence and qualifications of health care professionals, underwriting, premium rating, and other activities related to health insurance contracts, medical reviews, legal services, auditing functions, and business management and general administrative activities of Maranatha Natural Living, LLC.

I consent to allow Maranatha Natural Living, LLC to disclose my protected health information for treatment activities of another health care provider.

I consent to allow Maranatha Natural Living, LLC to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Maranatha Natural Living, LLC to disclose personal protected health information to another covered entity for health care operations activities, provided that Maranatha Natural Living, LLC and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment or health care operations or for the purpose of health care fraud and abuse detection or compliance.

Receipt of Privacy Practices for Maranatha Natural Living, LLC

Name of patient (Please print) \_\_\_\_\_

Signature of Person Authorizing Consent: \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Date \_\_\_\_\_



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## HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

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This consent was signed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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We schedule our appointments so that each patient receives the right amount of time to be seen by our provider. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Maranatha Natural Living, LLC sends text message and email reminders 5 days, 2 days, and 3 hours in advance of the appointment time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the provider, please give us at least 48 hours' notice.

If you do not cancel or reschedule your appointment with at least 48 hours' notice, we may assess a \$ 50.00 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of Maranatha Natural Living, LLC and agree to pay the \$ 50.00 fee within 30 days for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 48 hours in advance in order to avoid a potential no-show charge. Failure to pay result in termination of your relationship with our office. Your account must be up to date prior to your follow-up appointment.

Just a quick note if you choose to pay your copay or deductible using a credit card, a small 3% processing fee will be applied. We appreciate your understanding!

Patient's full name \_\_\_\_\_

Patient's signature \_\_\_\_\_

Today's date \_\_\_\_\_

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

**MEDICATIONS**

Medication Name (include all prescriptions, vitamins & over the counter)	Dose	Frequency	For what?

**ALLERGIES/CONTRAINDICATIONS**

○ No known allergies

Name	Reaction

**MEDICAL HISTORY**

Allergies	YES	NO	Depression	YES	NO	Myocardial Infarction	YES	NO
Anemia	YES	NO	Diabetes Mellitus	YES	NO	Nerve/Muscle Disease	YES	NO
Anxiety	YES	NO	Dexa/Bone Density	YES	NO	Osteoporosis	YES	NO
Arthritis	YES	NO	Emphysema	YES	NO	Seizures	YES	NO
Asthma	YES	NO	GERD	YES	NO	Shortness of Breath	YES	NO
Blood Transfusion	YES	NO	Glaucoma	YES	NO	Sickle Cell Anemia	YES	NO
Cancer	YES	NO	Heart Murmur	YES	NO	Stroke	YES	NO
Cataracts	YES	NO	High Cholesterol	YES	NO	Substance Abuse	YES	NO
Chest Pain	YES	NO	HIV/ AIDS	YES	NO	Thyroid Disease	YES	NO
CHF	YES	NO	Hypertension	YES	NO	Tuberculosis	YES	NO
Clotting Disorder	YES	NO	Kidney Disease	YES	NO	Ulcers	YES	NO
COPD	YES	NO	Meningitis	YES	NO	Migraines	YES	NO
Fatigue	YES	NO	Sleep Apnea	YES	NO			

Other Medical History: \_\_\_\_\_

**SURGICAL HISTORY**

AAA Repair	YES	NO	Colon Surgery	YES	NO	Joint Replacement	YES	NO
Appendectomy	YES	NO	Cosmetic Surgery	YES	NO	Intestine Surgery	YES	NO
Brain Surgery	YES	NO	Eye Surgery	YES	NO	Spine Surgery	YES	NO
CABG	YES	NO	Fracture Surgery	YES	NO	Tonsillectomy	YES	NO
Cholecystectomy	YES	NO	Hernia Repair	YES	NO	Tubal ligation	YES	NO
Colon/ Bowel Surgery	YES	NO	Hysterectomy	YES	NO	Valve Replacement	YES	NO
			Vasectomy	YES	NO	Prostate Surgery	YES	NO

Other Surgical History: \_\_\_\_\_

**FAMILY HISTORY**

Relationship	Alive?		Alcohol Abuse	Arthritis	Asthma	Autoimmune disorder	Cancer	COPD	Depression	Diabetes	Drug Abuse	Heart Disease	Hyperlipidemia	Hypertension	Kidney Disease	Learning Disability	Mental Illness	Stroke	Vision Loss	Other/Comments
	Y	N																		
Mother	<input type="checkbox"/>	<input type="checkbox"/>																		
Father	<input type="checkbox"/>	<input type="checkbox"/>																		
Sister 1	<input type="checkbox"/>	<input type="checkbox"/>																		
Sister 2	<input type="checkbox"/>	<input type="checkbox"/>																		
Sister 3	<input type="checkbox"/>	<input type="checkbox"/>																		
Brother 1	<input type="checkbox"/>	<input type="checkbox"/>																		
Brother 2	<input type="checkbox"/>	<input type="checkbox"/>																		
Brother 3	<input type="checkbox"/>	<input type="checkbox"/>																		
Son 1	<input type="checkbox"/>	<input type="checkbox"/>																		
Son 2	<input type="checkbox"/>	<input type="checkbox"/>																		
Daughter 1	<input type="checkbox"/>	<input type="checkbox"/>																		
Daughter 2	<input type="checkbox"/>	<input type="checkbox"/>																		
Mat GM	<input type="checkbox"/>	<input type="checkbox"/>																		
Mat GF	<input type="checkbox"/>	<input type="checkbox"/>																		
Pat GM	<input type="checkbox"/>	<input type="checkbox"/>																		
Pat GF	<input type="checkbox"/>	<input type="checkbox"/>																		
	<input type="checkbox"/>	<input type="checkbox"/>																		
	<input type="checkbox"/>	<input type="checkbox"/>																		
	<input type="checkbox"/>	<input type="checkbox"/>																		

Adopted

Family History Unknown

Other Family History: \_\_\_\_\_

**ALCOHOL SCREEN**

Have you ever had more than 4 drinks in a day?  Yes No

How many times in the past 12 months? 0 1 2 3 4 5+

**SOCIAL HISTORY**

Alcohol Use?  Yes No

Drinks/Week  Glasses of wine  
 Cans of beer  
 Shots of liquor  
 Drinks containing 0.5oz of alcohol

Sexually Active? Yes No Not Currently

Partners  Female Male

Birth Control/Protection:

- None
- Abstinence
- Coitus Interruptus
- Condom
- Implant
- Injection
- Inserts
- IUD
- OCP
- Patch
- Post-menopausal
- Rhythm
- Spermicide
- Sponge
- Surgical
- Other-see comments

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

Drug Use?  Yes No

Use/week \_\_\_\_\_ times a week

- Type
- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Amphetamines     | <input type="checkbox"/> Amyl Nitrate      | <input type="checkbox"/> Anabolic Steroids   | <input type="checkbox"/> Barbiturates |
| <input type="checkbox"/> Benzodiazepines  | <input type="checkbox"/> "Crack" cocaine   | <input type="checkbox"/> Cocaine             | <input type="checkbox"/> Codeine      |
| <input type="checkbox"/> Fentanyl         | <input type="checkbox"/> Other             | <input type="checkbox"/> GHB                 | <input type="checkbox"/> Hashish      |
| <input type="checkbox"/> Heroin           | <input type="checkbox"/> Hydrocodone       | <input type="checkbox"/> Hydromorphone       | <input type="checkbox"/> Ketamine     |
| <input type="checkbox"/> LSD              | <input type="checkbox"/> Marijuana         | <input type="checkbox"/> MDMA (Ecstasy)      | <input type="checkbox"/> Mescaline    |
| <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Methaqualone      | <input type="checkbox"/> Methylphenidate     | <input type="checkbox"/> Morphine     |
| <input type="checkbox"/> Nitrous Oxide    | <input type="checkbox"/> Opium             | <input type="checkbox"/> Oxycodone           | <input type="checkbox"/> PCP          |
| <input type="checkbox"/> Psilocybin       | <input type="checkbox"/> Solvent Inhalants | <input type="checkbox"/> Other- see comments |                                       |

Comments: \_\_\_\_\_

Tobacco Use?  Yes No

If so, Ready to Quit?  Yes No

Smoker, Currently # Packs/day: \_\_\_\_\_

Former Smoker, Previously Quit Date: \_\_\_\_\_ # Packs/day: \_\_\_\_\_

Smokeless Tobacco, Currently

Smokeless Tobacco, Previously Quit Date: \_\_\_\_\_ # Packs/day: \_\_\_\_\_

Comments: \_\_\_\_\_

### SOCIOECONOMIC HISTORY

Occupation: \_\_\_\_\_  Retired

Employer: \_\_\_\_\_

Spouse Name

\_\_\_\_\_

# of Children

\_\_\_\_\_

Language

English  Spanish  Chinese  French  Vietnamese  Arabic  German  Greek  Italian  Hindi  
 Russian  Sign Language  Thai  Somali  Other: \_\_\_\_\_

Ethnicity

Hispanic or Latino  Non-Hispanic or Latino

Race

Black/African American  White/Caucasian  Asian  American Indian  Hawaiian/Pacific Islander  
 Other  Refuse to answer

Lives with: \_\_\_\_\_

### HEALTH MAINTENANCE

Please document the date of last completion and results if appropriate for the following:

<u>Screening</u>	<u>Date Completed</u>	<u>Result/Comments</u>
Pap smear / pelvic (women only)		Normal or Abnormal?
Mammogram		Normal or Abnormal?
Colonoscopy		Normal or Abnormal?
DEXA./Bone Density Scan		Normal or Abnormal?
PSA (men only)		Normal or Abnormal?

**VACCINATIONS**

	<b>Have you received this vaccine?</b>	<b>Year(s) given</b>
Influenza vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Hepatitis vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Pneumonia Vaccine (Pneumovax or Prevnar13)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Tetanus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Tdap	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
Zoster/shingles vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
HPV vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
BCG (outside U.S.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	

**OTHER PHYSICIANS**

As your Primary Care Provider, it is our job to make sure we keep current with your other physicians and careteams. Please list your providers names below.

Heart specialist:	OB/GYN:
Digestive specialist:	Neurologist:
Endocrinologist:	Eye Doctor:
Orthopedist:	Pain Management:
Urologist:	Physical/Occ therapist:
Kidney specialist:	Dermatologist:
Counselor:	Cancer specialist:
Other:	

Are you interested in signing up for our Patient Portal, MyChart?  Yes  No



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