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: ____

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: _____ Insurance Type: 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
Gabriella 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 if 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:

_____

_____

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.

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/CONTRAINDICTIONS

○ 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: _____

NAME _____ DATE OF BIRTH_____

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
Mother	☐Y N☐																		
Father	☐Y N☐																		
Sister 1	☐Y N☐																		
Sister 2	☐Y N☐																		
Sister 3	☐Y N☐																		
Brother 1	☐Y N☐																		
Brother 2	☐Y N☐																		
Brother 3	☐Y N☐																		
Son 1	☐Y N☐																		
Son 2	☐Y N☐																		
Daughter 1	☐Y N☐																		
Daughter 2	☐Y N☐																		
Mat GM	☐Y N☐																		
Mat GF	☐Y N☐																		
Pat GM	☐Y N☐																		
Pat GF	☐Y N☐																		
	☐Y N☐																		
	☐Y N☐																		
	☐Y N☐																		

○ 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? ⓪①②③④⑤+

☐☐☐☐☐☐

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 ☐Diaphragm

☐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

☐ Amphetamines	☐ Amyl Nitrate	☐ Anabolic Steroids	☐ Barbiturates
☐ Benzodiazepines	☐ "Crack" cocaine	☐ Cocaine	☐ Codeine
☐ Fentanyl	☐ Other	☐ GHB	☐ Hashish
☐ Heroin	☐ Hydrocodone	☐ Hydromorphone	☐ Ketamine
☐ LSD	☐ Marijuana	☐ MDMA (Ecstasy)	☐ Mescaline
☐ Methamphetamines	☐ Methaqualone	☐ Methylphenidate	☐ Morphine
☐ Nitrous Oxide	☐ Opium	☐ Oxycodone	☐ PCP
☐ Psilocybin	☐ Solvent Inhalants	☐ 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:

Screening	Date Completed	Result/Comments
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?

NAME _____ DATE OF BIRTH_____

VACCINATIONS

	Have you received this vaccine?	Year(s) given
Influenza vaccine	☐Yes ☐No ☐Don't Know	
Hepatitis vaccine	☐Yes ☐No ☐Don't Know	
Pneumonia Vaccine (Pneumovax or Prevnar13)	☐Yes ☐No ☐Don't Know	
Tetanus	☐Yes ☐No ☐Don't Know	
TdaP	☐Yes ☐No ☐Don't Know	
Zoster/shingles vaccine	☐Yes ☐No ☐Don't Know	
HPV vaccine	☐Yes ☐No ☐Don't Know	
BCG (outside U.S.)	☐Yes ☐No ☐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:
Counseler:	Cancer specialist:
Other:	

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

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