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 _____

MARANATHA NATURAL LIVING, LLC
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PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other Concerns: _____

DEMOGRAPHICS: (Please check one for each category)

Race: ☐ American Indian ☐ Asian ☐ Black of African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Refuse

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Refuse

ALLERGIES:

Please list anything you are allergic to (medications, food, bee stings, etc.) and how each affects you:

Allergy:	Reaction
1. _____	_____
2. _____	_____
3. _____	_____

FAVORITE PHARMACY: _____

MEDICATIONS:

Please list all medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins/inhalers.

Drug Name:	Strength:	Frequency Taken:
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

IMMUNIZATION HISTORY:

Immunizations and most recent date:

- ☐ Chickenpox Date: _____
- ☐ Flu Shot Date: _____
- ☐ Gardasil/HPV Date: _____
- ☐ Hepatitis A Date: _____
- ☐ Hepatitis B Date: _____
- ☐ Meningococcus Date: _____
- ☐ MMR (Measles, Mumps, Rubella) Date: _____
- ☐ Pneumonia (Pneumovax) Date: _____
- ☐ Tdap (Tetanus and Pertussis) Date: _____
- ☐ Tetanus Date: _____
- ☐ Zostavax (Shingles) Date: _____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY:

Last PAP Smear Date: _____ ☐ Abnormal

Last Mammogram Date: _____ ☐ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ Births: _____

Miscarriages: _____ Abortions: _____

☐ Cesarean Sections If yes, then number of: _____

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast Lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active
  Current sexual partner is ☐ M ☐ F
  Do you use condoms? ☐ Yes ☐ No
  Other birth control method: _____
  ☐ Interested in being screened for STD's

PAST MEDICAL HISTORY:

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
  - Type: _____
- ☐ Coronary Artery Disease
- ☐ Diabetes – Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulosis/Diverticulitis
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ Gout
- ☐ Heart Attack
- ☐ Heartburn
- ☐ Heart Murmur
- ☐ Hiatal Hernia
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg-Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peptic Ulcer Disease
- ☐ Pulmonary Embolism
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Other: _____
  _____

PAST SURGICAL HISTORY:

Surgery:	Year:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

FAMILY HEALTH HISTORY:

If any of the following family members have been diagnosed with Cancer (if so, what type), Diabetes, Heart Disease, Hypertension, or any other major disease/illness, please fill in the following:

Family Member:	Alive Y/N:	Age:	Disease(s)/Illness:
Mother	_____	_____	_____
Father	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Sibling (Circle): Brother / Sister	_____	_____	_____
Sibling (Circle): Brother / Sister	_____	_____	_____
Sibling (Circle): Brother / Sister	_____	_____	_____
Sibling (Circle): Brother / Sister	_____	_____	_____
Sibling (Circle): Brother / Sister	_____	_____	_____

PRENATAL HISTORY

Problems: (Check all that apply)

- ☐ Multiple Gestation
- ☐ Infections
- ☐ Gestational Diabetes
- ☐ Bleeding
- ☐ Herpes
- ☐ Growth Delay
- ☐ Abnormal AFP
- ☐ Abnormal Ultrasound

□ Pregnancy Medications □ HIV

□ Hepatitis

Notes:

_____

_____

_____

BIRTH HISTORY

Problems: (Check all that apply)

□ Fetal Distress □ Premature Rupture of Membranes

□ Infection □ Scalp Bruise

□ Breathing Problems □ C-Section

□ Clavicle Fracture □ Vacuum

□ Intubation □ Maternal Infections

□ NICU Admit □ Preterm Labor

Notes:

_____

_____

_____

SOCIAL HISTORY:

Check one answer for each of the following categories:

Diet: □ Regular □ Vegetarian □ Vegan □ Gluten Free □ Specific □ Carbohydrate

Exercise Level: □ None □ Occasional □ Moderate □ Heavy

Parent's Marital Status: □ Married □ Unmarried □ Separated □ Divorced □ Widowed

Childcare: □ None □ Relative □ Private Sitter □ Daycare/Preschool

Second Hand Smoke Exposure: □ Yes □ No

Seat Belt/Car Seat used Routinely: □ Yes □ No

Does the Patient Smoke? □ Yes □ No