ADVANCED INTEGRATIVE MEDICINE

# REGISTRATION FORM

(Please Print)

| Today's date: | PCP: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | Race: Ethnicity: | Birth date: | Age: | Sex: ❑ Other ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Social Security no.: | Home phone no.: ( ) |
|---|---|---|

| City/ State | Zip Code: | Cell phone: ( ) | Preferred number for voice contact: Home Cell Work |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) |
|---|---|---|

**PHARMACY INFORMATION:**

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**MAIL ORDER PHARMACY:**

**PHONE:**

| Other family members seen here: | Chose/referred to our clinic because: |
|---|---|

Email Address:____________________________________________________________

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand that payment is my responsibility regardless of insurance coverage. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency and may be dismissed from AIM. I understand that any missed appointments without 24 hour notice will result in a $25 or $50 fee, depending on visit type. A $15 returned check fee will be charged for checks returned due to insufficient funds. I also authorize ADVANCED INTEGRATIVE MEDICINE or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*

**PLEASE BE AWARE YOUR INSURANCE MAY BE CHARGED BETWEEN $300-$450 FOR THIS INITIAL VISIT. CASH PAY IS AVAILABLE AT A CHEAPER RATE FOR HIGH DEDUCTIBLE PATIENTS.**

**ADVANCED INTEGRATIVE MEDICINE**
10455 Park Meadows Drive Unit 102
Lone Tree, Colorado 80124

# HIPAA Privacy Rights Form

**PATIENT INFORMATION**

Date

Name (Last, first, middle initial)

Social Security # or Patient ID

Street address, City, ST, ZIP Code

Primary phone number | Other phone number

Email address

**Please list below how you would like to be contacted with results or medical issues:**

☐ Home Phone________ ☐ Cell phone________ ☐ Text Message
☐ Work Phone________ ☐ ________ ☐ ________

Please list below the person or persons that may receive your test results or whom we may discuss your medical issues with:

**Please list the phone numbers you authorize Advanced Integrative Medicine to call** and leave test results, confirmation calls, or detailed medical issues on:

Phone number

Date

Phone number

Date

**I authorize Advanced Integrative Medicine to leave medical results on my personal voicemail** YES NO

**I have read the Notice of Privacy Practices** YES NO

**SIGNATURE:**

DATE:

Privacy Official signature

Date

Attach additional documentation, if applicable.

## AUTHORIZATION TO RECEIVE MEDICAL INFORMATION ONLINE OR BY FIRST CLASS U.S. MAIL

1. RISK OF USING THE INTERNET OR FIRST CLASS U.S. MAIL TO RECEIVE MEDICAL RECORDS. Advanced Integrative Medicine, PC (the "Practice") offers patients the opportunity to receive medical records (including lab results) online or by first class U.S. mail. Transmitting patient information online or by first class U.S. mail, however, has a number of risks that patients should consider before using these methods (the "Risk"). These Risks include, but are not limited to, the following:

- Storing patient records online can be subject to theft by third party hackers (who may then try to sell or publicize such records).
- If you do not properly secure your login and password, others may be able to access your records.
- First class U.S. mail can be lost, stolen, or delivered to the wrong address, potentially resulting in third parties having access to your records.
- First class U.S. mail may be opened by others living or visiting at your address.

2. CONDITIONS FOR THE USE OF THE INTERNET AND FIRST CLASS U.S. MAIL. The Practice will use reasonable means to protect the security and confidentiality of records stored online or sent by first class U.S. mail. However, because of the Risks outlined above, the Practice cannot guarantee the security and confidentiality of receiving records online or by first class U.S. mail, and will not be liable for improper use and/or disclosure of your confidential medical information (including Protected Health Information that is the subject of the federal Health Insurance Portability and Accountability Act of 1996, as amended) that is not caused by the Practice's intentional misconduct. Thus, patients must consent to receiving medical records online or by first class U.S. mail. The patient is responsible for informing the Practice of any types of information the patient does not want to be received online or by first class U.S. mail. The patient is also responsible for protecting his/her password or other means of access to online records and taking precautions to preserve the confidentiality of online access, such as using screen savers and safeguarding his/her computer password. The Practice is not liable for breaches of confidentiality caused by the patient or any third party.

3. PATIENT ACKNOWLEDGMENT AND AGREEMENT. I acknowledge that I have read and fully understand the information the Practice has provided me regarding the Risks of receiving medical records online or by first class U.S. mail. I understand such Ricks and consent to the conditions outlined in this document. In addition, I agree to the instructions outlined above, as well as any other instructions that the Practice may impose regarding these matters.

______________________________

Patient Printed Name

______________

Date of Birth

______________________________

Signature of Patient or Personal Representative

______________

Date

______________________________

Personal Representative Relationship To Patient

# PATIENT INFORMATION SHEET

ADVANCED INTEGRATIVE MEDICINE

NAME:_________________________ DOB:_________________ DATE:________________

ALLERGIES:_________________________________________________________________

SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:__________ Exercise: times per week________

Alcohol: Currently Past Never Drinks/day:_________ Occupation____________________

Caffeine: Currently Past Never Drinks/day:_________

List ALL MEDICATIONS you take, including over the counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know please call your pharmacist to confirm

| Medications/dose/frequency | OTC and Vitamins/dose/frequency |
|---|---|
| | |
| | |
| | |
| | |

PREVENTATIVE HISTORY: (PLEASE FILL OUT WITH APPROXIMATE DATE)

| | | | |
|---|---|---|---|
| Flu Vaccine | Date: | Measles Vaccine | Date: |
| Pneumovax(pneumonia) | Date: | Shingles Vaccine | Date: |
| Tdap Vaccine(tetnus,pertussis) | Date: | Tuberculin PPD skin test | Date: |
| Colonoscopy | Date: Normal/ Abnormal | Dxa (Bone Density) | Date: Normal/Abnormal |
| **Female Patients:** | | | |
| Last Menstrual Period | Date: Normal/ Abnormal | Mammogram | Date: Normal/Abnormal |
| Total number of pregnancies: | | Pap smears: | Date: Normal/Abnormal |
| Total number of miscarriages or abortions: | | Uses birth control: | |

SURGERY AND PROCEDURE HISTORY: (circle)

| | | | |
|---|---|---|---|
| NO prior surgical history | Colon surgery | Hernia | Tonsillectomy |
| Appendectomy | Gall Bladder surgery | Hysterectomy | Tubal ligation |
| Breast Lumpectomy | Heart surgery | Mastectomy | Vasectomy |
| Cataract surgery | Hemorrhoids | Back/ spine surgery | |

OTHER HOSPITALIZATIONS/SURGERIES:_____________________________________________

_______________________________________________________________________

.**PERSONAL MEDICAL HISTORY:** (please circle/fill in all that apply)

| ADHD | Dementia | Hernia | Parkinson's Disease |
|---|---|---|---|
| Alcoholism | Depression/Anxiety | Hepatitis | Peripheral Vascular |
| Allergies, Seasonal | Diabetes: 1 or 2 | High Cholesterol | Peptic Ulcer |
| Anemia | Diverticulitis | High Blood Pressure | Psoriasis |
| Arthritis | DVT (blood clot) | HIV/Aids | Pulmonary Embolism |
| Asthma | Eczema | Irritable Bowel Synd. | Rheumatoid Arthritis |
| Bipolar | Emphysema/COPD | Kidney Disease | Sciatica |
| Bladder problems/ Incontinence | Gallstones | Kidney Stones | Seizure Disorder |
| Bleeding problems | GERD (acid reflux) | Lupus | Sleep Apnea |
| Carpal Tunnel | Glaucoma | Liver Disease | Stroke |
| Cancer: | Headaches/Migraine | Macular Degener. | Thyroid Disorder |
| Crohn's / Colitis | Heart Attack (MI) | Neuropathy | |
| Osteopenia/osteoporosis | Heart Disease | Nose Bleeds | |
| | | | |

**Other medical problems not listed above:** ______________________________

______________________________

**FAMILY HISTORY:**

**FATHER:** Living: Age________ Deceased: Age________

| Alcoholism | Blood Clot/DVT | Depression | Kidney Disease |
|---|---|---|---|
| Anemia | Bipolar | Diabetes 1 or 2 | Osteoporosis |
| Asthma | COPD/emphysema | High Cholesterol | Stroke |
| Arthritis | Dementia | High Blood Pressure | Thyroid Disorder |
| Cancer: | | | |
| Other: | | | |

**MOTHER:** Living: Age________ Deceased: Age________

| Alcoholism | Blood Clot/DVT | Depression | Kidney Disease |
|---|---|---|---|
| Anemia | Bipolar | Diabetes 1 or 2 | Osteoporosis |
| Asthma | COPD/emphysema | High Cholesterol | Stroke |
| Arthritis | Dementia | High Blood Pressure | Thyroid Disorder |
| Cancer: | | | |
| Other: | | | |

**SIBLINGS:** ______________________________

______________________________

**List other medical providers that you see on a regular basis** ( i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

______________________________

______________________________

PATIENT SIGNATURE:______________________ DATE:____________

PROVIDER REVIEWED:______________________ DATE:____________