NEW PATIENT INFORMATION 1

PATIENT NAME:

Parent(s)/Guardian Name(s) if Patient is a Minor:

PRIMARY ADDRESS:

PRIMARY PHONE:
Is this your Home/cell/work phone?

SECONDARY PHONE:
Is this your Home/cell/work phone?

DATE OF BIRTH:

OCCUPATION:

EDUCATION:

EMAIL ADDRESS:

Circle one: Single Married Life-partner Divorced Widowed

Circle one: Female Male Transgender

Please explain your main concern(s) prompting you to consult with us

MEDICAL HISTORY:

Recurring problems:

Major illnesses and/or hospitalizations:

Surgeries:

Current medications (attach list if needed):

Current supplements (attach list if needed):

Recent physicians and other medical professionals:

Recent tests and results (bring copies of bloodwork or reports if possible):

Allergies to medications:

Environmental allergies:

Toxic exposure history:

Trauma (physical and/or emotional):

What are your treatment goals (what do you hope to accomplish as a result of working with us)?

FAMILY HISTORY:

Mother's age:_____ or deceased at age:_____Medical problems:

Father's age:_____ or deceased at age:_____ Medical problems:

# of Sisters:_____ ages: _____ Medical problems:

# of Brothers:_____ ages: _____ Medical problems:

# of Children: _____ ages:_____ Medical problems:

Others, if significant (grandparents, aunts/uncles, etc.):

SOCIAL HISTORY:

Hobbies:

Use of tobacco (now and in the past):

Menthol cigarette use now? YES NO

Caffeine intake (coffee, tea, energy drinks):

Use of alcohol (now and in the past):

Recreational drug use (now and in the past):

Are you concerned about your use of alcohol or other substances?

Do you get regular physical activity/exercise?

Do you have concerns about your diet?

Do you follow any particular diet or have dietary restrictions (vegan, vegetarian, paleo, gluten-free, dairy-free, soy-free, etc.)?

Do you feel safe in your home environment?

TESTING:

When was your most recent:

_____ Bloodwork
_____Colonoscopy/Cologuard
_____Annual physical
_____Vitamin D screening
_____Pap/pelvic (women)
_____Rectal/prostate exam (men)
_____Mammogram/breast thermogram
_____Chest CT (smokers, former heavy smokers)
_____Vaccinations

Please bring copies of any bloodwork and/or test results from the last 1-2 yrs.

The information on this form applies to the person(s) **financially responsible** for the patient's account. If this information is the same as the Patient Info already filled out above, you can leave this area blank, and move on to PAGE 7.

IF YOU ARE A PARENT FILLING OUT THIS FORM, PLEASE FILL OUT THIS PAGE.

Last Name:

First Name:

Date of Birth:

Address (if different from above):

Email:

Primary Phone: Secondary Phone:

If applicable to the patient:

Spouse/Partner Information:

Last Name:

First:

Address (if different from above):

Primary Phone: Secondary Phone:

Please list your Children's Names and Ages:

How did you hear about us?

Preferred Pharmacy with Phone #:

Preferred Hospital:

Nearest Relative not at your address, with Phone #:

In case of emergency, who do we contact?

What is their relationship to you?

ALL PATIENTS PLEASE READ and SIGN IN 3 PLACES BELOW:

Consent for Homeopathic/Holistic Medical Care:
I, the undersigned, accepting responsibility for educating myself regarding the major differences between homeopathic/holistic and conventional medical care, do hereby acknowledge my desire and consent to such treatment for myself or my dependent. I understand that by seeking a homeopathic/holistic approach to treatment that I will be receiving medical care according to the prevailing standard of the homeopathic medical community, as expressed by the American Institute of Homeopathy, and/or the prevailing standards of the other holistic professional associations relevant to the type of care received. I understand that this type of care may not always include the medications, screenings, physical exam, X-rays, blood or other laboratory tests that are the prevailing standard of conventional care.

I also understand that I am financially responsible for my account and/or my dependent's account. A copy of this signature is as valid as the original.

Patient Name
(printed):_____

Signed:_____Date:_____

Medical Malpractice and Medicare:

Karin Cseak, DO, who is a valid certificate holder of a medical license to practice Osteopathic Medicine in the state of Ohio, is not covered by medical malpractice insurance.

Karin Cseak, DO, has opted out of the Medicare program, effective Oct. 1, 2014, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act. Medicare cannot be billed for any services rendered by Dr. Cseak, and the Patient is responsible for all fees incurred for services by Dr. Cseak and/or her staff.

The undersigned acknowledges the receipt of these notices.

Signed: _____Date:_____

HIPAA Compliance Patient Consent:

Our Notice of Privacy Practices (below) 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 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. 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 operation

____The practice reserves the right to change the privacy policy as allowed by law

____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 you to confirm appointments? YES / NO

May we leave detailed messages on your answering machine at home or on your cell? YES / NO

May we leave detailed messages at your place of employment? YES / NO

May we email to your specified email address personal private health information including but not limited to laboratory reports, treatment, recommendations, relevant scientific articles and medical forms? YES / NO

Would you like a copy of our Notice of Privacy Practices (initial one): YES_____NO_____

Print Name: _____

Signature:_____Date:_____

AUTHORIZATION TO DISCLOSE (optional):

I, the undersigned, authorize Family Holistic Health to disclose my medical information and/or discuss my medical information with the following person(s):

Spouse/Partner:

Name: _____

Phone: _____

Adult Children:

Name: _____

Phone: _____

Name: _____

Phone: _____

Please use the back of this form for additional children.

Friend/Relative:

Name: _____

Phone: _____

Name: _____

Phone: _____

Print your Name: _____

Signature: _____ Date: _____