Center for Preventive Medicine
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Welcome to our office. We are happy that you have chosen to come to us for your complementary healthcare. Our Office policies are designed to assure that we are able to provide the quality of care you expect from us, and that all of our patients are able to receive their care promptly and with minimal waiting times. This letter explains our office policies. Please take a few minutes to read it, sign it and return it to our staff with your patient information forms. We look forward to meeting you.

The undersigned acknowledges that he/she has requested healthcare services from the Center for Preventive Medicine. Many of the therapies offered at the Center are considered unconventional by mainstream medical establishment. Although some treatments have been in continuous use for a long period of time, they have been deemed "unproven" by such organizations as the American Medical Association, the Food and Drug Administration and certain insurance companies. Any therapy suggested to you can, of course, be refused and/or terminated at any time to receive only conventional therapies without the use of alternative or complementary modalities. Under no circumstance are you obligated to accept any treatment offered to you.

Disclosure of Information

All information provided to the Center for Preventive Medicine staff and clinicians is strictly confidential except for the following circumstances:

- Your insurance company requests information about your treatment in order to process a claim or certify care.
- The patient authorizes the release of information by signing a release form naming the specific person to receive the information.
- Certain circumstances where we are required by law to release information (e.g. court subpoena, suspected abuse, etc.)

Financial Terms

You are expected to pay for your care in full at the time services are rendered. We will provide you with a universal health insurance claim form so that you may submit a claim to your insurance company for reimbursement. We do not participate with any insurance companies, and do not submit insurance claims. If an amount owed by a patient is not received on a timely basis, the patient may be responsible for reasonable attorney fees and the cost of collection. There is a $35 charge for copying medical records, and there is a $25 fee for returned checks.

Canceled/Missed Appointments and Late Arrivals

When you make an appointment, we are reserving time on a practitioner's schedule that is no longer available to other patients. We do require a $100 deposit for all new patient appointments; which will be applied to the first visit. If you cannot make an appointment, we ask that you cancel your appointment at least 24 hours in advance. A new patient deposit will be refunded if you give 24 hours advance notice of cancellation. The Center's voice mail message center 603-673-7910 accepts messages about appointment cancellations at any time (24 hours/day). Missed appointments will result in a $50 charge.

Late arrivals can create scheduling problems with other patients. If you must be late, please call to let us know. If you arrive more than 15 minutes late, we may not be able to accommodate your appointment without interfering with the scheduled times of the other patients.

Acknowledgement and Agreement

I have read the above information and thoroughly acknowledge, understand, and agree to all of the above information, including the financial terms as stated above.

Patient (or Parent/Guardian) PRINTED   Signature   Date

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PEDIATRIC VISIT MEDICAL HEALTH AND HISTORY FORM

(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	MI:	Grade in School:	Date of birth: / Gender: ☐ M ☐ F	Age:

Parent /Guardian last name:	First:	MI:
Parent/Guardian last name:	First:	MI:

Street address:	Social Security no.:	Home phone no.: ( )	Mobile phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

How did you hear of us? (Please check one box): ☐ Dr. ___________ ☐ Internet ☐ Hospital

☐ Family___________ ☐ Friend ___________ ☐ Close to home/work ☐ Yellow Pages ☐ Other___________

Other family members seen here:	E-mail address:

INSURANCE INFORMATION

Insurance Company:	Policy #:	Insured's Name (Policy Holder):	Group Name or #:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work/Cell phone no.: ( )

PRIMARY COMPLAINT

Please list your major problems and /or symptoms and the approximate date it began (If none, please write your reason for this consultation). Please rank in order of importance to you.

	When problem began:
1.	
2.	
3.	

ALLERGIES

Please list any known allergies;

DRUGS, FOODS, ENVIRONMENTAL, ETC:

Please list any known allergies:

OVER→

Pharmacy Name and Address:	Pharmacy Phone #:

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CURRENT MEDICATIONS/DIETARY SUPPLEMENTS

Please write the name, dosage and frequency of all current medications:

Name:	Dosage:	Frequency:

Vaccination History (What vaccine's if any and when?) **OR** Provide a copy of the original vaccination information, if possible.

PRIMARY CARE PROVIDER/PEDIATRICIAN

Do you have a primary care provider? Yes/No If yes, please complete the information below:

Name and Address:	Office Phone: ( )
Has the child been seen by any other doctor(s) for this complaint? ☐ Yes ☐ No	

HOSPITALIZATIONS AND SURGERIES

Date	Type or Reason

CHILD'S TEST INFORMATION

Please specify when your tests were done if possible:

Current Height	feet inches	Current Weight	pounds
Last physical exam		X-rays	
Hearing Tests		Vision Tests	
Speech Impediments		Learning Impediments	
Blood tests		Other tests	

TYPICAL DAYS' DIET

Breakfast:	
Lunch:	
Dinner:	
Snacks:	

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EXPOSURES

Any particular household stressors the child has witnessed or gone through? Please list:

1.	3.
2.	4.

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? ☐ Yes ☐ No
If yes, to what sort of pollution were they exposed?

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health? ☐ Yes ☐ No
If yes, please explain:

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? ☐ Yes ☐ No

Do you spray pesticides, herbicides or other chemicals around your home? ☐ Yes ☐ No

CHILD'S ILLNESS HISTORY

YES indicates the child gets the problem **regularly**; NO indicates the child **never** had the problem; PAST indicates the child had the problem in the **past, but not recently**.

Ear Infections	☐ Yes ☐ No ☐ Past	If yes, how many total:
Colds	☐ Yes ☐ No ☐ Past	If yes, how many total:
Strep Throat	☐ Yes ☐ No ☐ Past	If yes, how many total:

CHILD'S HEALTH HISTORY

YES indicates the child gets the problem **regularly**; NO indicates the child **never** had the problem; PAST indicates the child had the problem in the **past, but not recently**.

Child Breastfed?	☐ Yes ☐ No	If yes, how long?	When was child put on formula?	Which formula?

When was child put on solid food?	When did child walk?	Talk?	Develop teeth?

Jaundice as baby	☐ Yes ☐ No	Colic	☐ Yes ☐ No	Cradle Cap	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Eczema or Psoriasis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No	Warts	☐ Yes ☐ No	Constipation	☐ Yes ☐ No
Nightmares	☐ Yes ☐ No	Finicky Eating	☐ Yes ☐ No	Bed-wetting	☐ Yes ☐ No
Poor Teeth	☐ Yes ☐ No	Tantrums	☐ Yes ☐ No	Chronic Sniffles	☐ Yes ☐ No
Disobedient	☐ Yes ☐ No	Bad Foot Odor	☐ Yes ☐ No	Fears/Phobia	☐ Yes ☐ No
Very Sweaty Baby/Child	☐ Yes ☐ No	Diaper Rash	☐ Yes ☐ No	Hyperactivity	☐ Yes ☐ No
Early Puberty	☐ Yes ☐ No	Growing Pains	☐ Yes ☐ No	Stomach Aches	☐ Yes ☐ No

FAMILY HISTORY

Allergies	☐ Yes ☐ No ☐ Past	Obesity	☐ Yes ☐ No ☐ Past	Cancer	☐ Yes ☐ No ☐ Past
Tuberculosis	☐ Yes ☐ No ☐ Past	Mental Illness	☐ Yes ☐ No ☐ Past	Cardiovascular Disease	☐ Yes ☐ No ☐ Past
Diabetes Mellitus	☐ Yes ☐ No ☐ Past				

MOTHER'S PREGNANCY HISTORY

Age at conception:			Did she have other children already? ☐ Yes ☐ No		
Smoking	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Coffee	☐ Yes ☐ No
Nausea/Vomiting	☐ Yes ☐ No	Recreational Drugs	☐ Yes ☐ No	Emotional Stress	☐ Yes ☐ No
Preeclampsia	☐ Yes ☐ No	Length of Labor		Vaginal Birth	☐ Yes ☐ No
Traumatic Birth	☐ Yes ☐ No	If birth was difficult, please explain:			
Health of baby at birth:					