Zest
natural medicine
Providing Naturopathic Primary Care

PEDIATRIC INTAKE FORM (Birth- 5 years)

Patient's name: _____ Date of first visit: _____

Age: _____ Date of Birth: _____/_____/_____ Gender: female _____ male _____

Mother's name:_____Father's name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone # (home): (_____)_____ Parents # (work): (_____)_____

Parents e-mail address: _____

How did you hear about this clinic? _____

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept:

_____

Reason for referral or presenting problems:

_____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects _____Hypertension

_____ Arthritis _____ Tuberculosis _____ Cancer _____Allergies

_____ Mental illness _____Auto-immune conditions

MEDICATIONS

	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofin	_____	_____	Allergies to medicines _____		

CHILDHOOD ILLNESSES/ VACCINATIONS

(Please circle all that apply)

Did your child have the following:	Diseases (D)	Get Immunized (I)	Neither (N)

Measles:	D I N	Chicken Pox:	D I N	Mumps:	D I N	Rubella:	D I N
Tetanus:	D I N	Whooping Cough:	D I N	Hemophilus (Hib):	D I N	Hep B:	D I N
German measles:	D I N						

Any vaccine reactions? _____

MEDICAL HISTORY

_____ Scarlet fever _____Rheumatic fever _____ Measles _____ Pneumonia _____ Frequent colds

_____Tonsillitis, how many times? _____ _____Ear infections, how many times? _____

other (please list) _____

Has your child had any of the following tests?	When	Where	Results
Electroencephalogram			
Psychological evaluation			
Hearing			
Speech/Language			

Injuries/Surgeries/Hospitalizations (please list):

_____

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

_____

Mother's age at child's birth? _____

Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma

_____ Nausea _____ Cigarettes, alcohol, drug consumption

_____ Illnesses _____ Medications

_____ Hypertension _____ Thyroid problems _____ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth_____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

_____ Birth defects _____Birth injuries _____Blue baby

_____ Cerebral palsy _____Seizures _____Jaundice

_____ Colic _____Fever _____ Rashes

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast fed? _____ how long? _____ Formula? _____ milk / soy _____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

(mark **Y** if current, **P** significant past symptom)

_____ Hives	_____Burning of urine	_____Bloody urine
_____ Eczema	_____Frequent urination	_____Cries easily
_____ Bleeding gums	_____Heart murmur	_____Nervous
_____ Nose bleeds	_____ Vomiting spells	_____Sleep problems
_____ Acne	_____Anemia	_____Night sweats
_____ High fevers	_____Stomach aches	_____Sensitive to light
_____ Chronic rash	_____Jaundice	_____Body/breath odor
_____ Hearing loss	_____Easy bruising	_____Motion/car sickness
_____ Diarrhea	_____Flat feet	_____No appetite
_____ Sore throats	_____Constipation	_____ Nightmares
_____ Headaches	_____ Gas	_____Canker sores
_____ Frequent colds	_____Bleeding tendency	_____ Unusual fears
_____ Wheezing	_____Joint pains	_____Excessive fatigue
_____ Cough	_____Dizzy spells	_____Hair loss

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Thank you. We look forward to helping your child in any way we can.

Payment Agreement

Dear New Patient,
Welcome to Zest Natural Medicine. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

_____ Payment for all services and medicinary items is due at the time of the visit. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a $35.00 NSF fee.

_____ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment. Phone and email charges are not billable to insurance.

_____ You will be charged a Missed Appointment Fee of $50.00 for any missed appointments or late cancellations (less then 24 hours notice).

Your health care provider may prescribe medication, which may be purchased at Zest Natural Medicine or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of Zest Natural Medicine and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____
Patient Signature (Parent/guardian signature if minor) Date

1405 N Dobson Road • Suite 20 • Chandler, AZ 85224 • (480) 361-5108• Fax: (480) 361-7058 •
www.zestnaturalmedicine.com

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E-MAIL AGREEMENT

E-Mail Authorization and Consent Agreement Between Zest Natural Medicine and Patient

I have been advised that:

- E-mail is never, ever appropriate for urgent or emergency problems.
- E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
- E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.
- There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.
- All e-mail correspondence will become a part of my medical record at Zest Natural Medicine. It is extremely important to include my name on each and every e-mail sent to Zest Natural Medicine and/or Dr. Kohler / Dr. Zeller.
- Since e-mail may not be monitored while my clinician is away on business or on vacation, I will follow-up by telephone or in person if I do not receive a response within a week.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.

I have been provided with information about the use of Internet e-mail communications between my health provider, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting my clinician.

I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address:

Please print clearly:_____
Internet e-mail address (sample format: jdoe@aol.com)

Signature:_____Date:_____

Name:_____DOB:_____

Name of Physician (print):_____

Signature of Physician:_____

Notice of Privacy Policy

To our patients at Zest Natural Medicine:

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. **We are required by law to maintain the confidentiality of your health information.** We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health information to only certain individuals involved in you care or the payment for your care, such as family members and friends; We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Zest Natural Medicine, 1405 N. Dobson Road, Suite 9, Chandler, AZ 85224. Note: *We must respond to this request in 30 days.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Zest Natural Medicine, 1405 N. Dobson Road, Suite 9, Chandler, AZ 85224. You must provide us with a reason that supports your request for amendment. Note: *We must respond within 60 days. The Privacy Officer of the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice any time. To obtain a copy of this notice, contact Zest Natural Medicine.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Zest Natural Medicine. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information policies, please contact the office of Zest Natural Medicine at (480)-361-5108.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Zest Natural Medicine's Notice of Privacy Practices.

_____

Patient or legally authorized individual signature **Date**

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

I authorize and agree that *Zest Natural Medicine* may disclose my protected health information to the following persons each of whom is directly involved in my care:

1. _____ 3. _____

2. _____ 4. _____

I acknowledge and agree that Zest Natural Medicine may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to Zest Natural Medicine.

_____

Patient or legally authorized individual signature **Date**

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because (please specify):_____

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