Desert Wellness Center

Family Medicine using Modern Science and Ancient Wisdom

Patient Information Form

Name:____________________________________ DOB:_____________________________________

Address:__________________________________ Home Phone:_______________________________

__________________________________ Cell Phone:_________________________________

Email:____

In the Event of an Emergency, Please Contact:____

Relationship to the Patient:______________________________ Phone Number:________________________

Insurance Company:____

Group Number:______________________________ Policy Number:________________________________

Claims Address:____

Insured:_____________________________________ Relation to Patient:___________________________

Financial Policy:

Thank you for selecting Dr. Courtney Cronin, NMD for your health care needs. We are honored to be of service to you and your family. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. If you should desire to submit costs associated with your care to your insurance company, Desert Wellness Center will provide you with the necessary codes, but Desert Wellness Center does not guarantee that your insurance will reimburse any of those expenses.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs. I have read and understand all of the above and have agreed to these statements.

____ ____

Patient's Signature Date

I acknowledge that I have received a copy of Desert Wellness Center's Notice of Privacy Practices.

Patient or legally authorized individual signature Date

Printed Name if signed on behalf of the patient Relationship to patient

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New Patient Intake

Name: ________________________________ Date of Birth:_____________ Today's Date:_____________

List of Complaints (in order of importance):
1. ____
2. ____
3. ____
4. ____
5. ____

Allergies to Medications/Food:
1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________

Weight History

When did you first become overweight? (your age then) ________________ (year) __________________________

How did your weight gain start? Describe any circumstances: ____

____

What do you think is the cause of your weight problem? ____

____

Your present weight: _____________________ your weight goal: __________________ height: _________________

What was your highest weight? (excluding pregnancy) ___________your age then _______# of years ago __________

What was your lowest weight? _____________________________your age then ________# of years ago __________

Have you ever stayed the same weight for 10 years or more? Yes/ No

Have you attempted to lose weight before? ___________________ most lbs lost: ________ how long it took: _______

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results:____

____

____

Where and when do you do most of your overeating?____

____

Please make any comments that you think might be helpful: ____

____

____

____

Exercise: How often: __________________ Type: ____________________________

Sleep: Amount: _____________ Wake Refreshed?__________ Trouble Falling or Staying Asleep?__________

Please describe your typical meals:

Breakfast	Lunch	Dinner

Snacks:_______________________________ Beverages:____

2133 E. Warner Rd., #102 Phone: (480) 820-6695 www.DesertWellnessCenter.com
Tempe, Az 85284 Fax: (480) 820-6696 info@DesertWellnessCenter.com

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Current Medications and Supplements (include dosage): ____

____

____

____

Previous Surgeries and Hospitalizations, include date: ____

____

____

Please list date of your last:

Blood Work:____________________ Dental Exam:___________________ Eye Exam: ____________________

Colonoscopy:___________________ Chest x-ray:____________________ Other Imaging:_________________

Pap Smear:_____________________ Bone Scan:_____________________ Mammogram:__________________

Please indicate if you have had the disease (D) or were immunized (I):

Measles: D I Mumps: D I Rubella: D I Hemophilis (Hib): D I

Tetanus: D I Shingles: D I Chicken Pox: D I Hepatitis B: D I

HPV: D I Whooping Cough: D I German Measles: D I Other:_____________________

Family History

Family Member	**Age if Living**	**Age of Death**	**Reason of Death**
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

Disease	**Family Member**
Heart attack/stroke	
Cancer (include type)	
Mental Illness	
Heart Disease	
High Blood Pressure	
Diabetes	
Asthma/allergies	
Autoimmune(RA,Lupus,etc)	

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Please indicate Yes (Y), No (N), or Past (P):

Antacids: Y N P Smoking: Y N P Packs per day & number of years ___________________________

Analgesics: Y N P Coffee: Y N P Cups per day if yes or past_________________________________

Laxatives Y N P Alcohol Y N P Amount if yes or past_____________________________________

Steroids Y N P Soda Y N P Amount if yes or past ____________________________________

Recreational Drugs Y N P

Addictions and/or treatment for addictions: Y N P Explain: _________________________________

Social Life:

Job: ____ Enjoy Job? ___________________________

Hobbies: ____

Relationship: Married Single In a relationship

Satisfied with Significant Relationship? ____

History of Mental/Physical/emotional Abuse? ____

Review of Systems

Circle Yes (Y), No (N) or Past (P):

Skin:

Rash: Y N P	Eczema: Y N P	Color Change: Y N P
Hives: Y N P	Cancer: Y N P	Abnormal Mole: Y N P
Psoriasis: Y N P	Warts: Y N P	Dry/ Itchy: Y N P

Head:

Migraines: Y N P	Dandruff: Y N P	Oily/dry Hair: Y N P
Headache: Y N P	Hair Loss: Y N P	Head Injury: Y N P

Nose:

Nose bleeds: Y N P	Allergies: Y N P	Frequent Colds Y N P
Polyps: Y N P	Congestion: Y N P	Problems Smelling Y N P

Eyes:

Dryness: Y N P	Cataracts: Y N P	Pain: Y N P
Itching: Y N P	Glaucoma: Y N P	Watery/Discharge: Y N P
Redness: Y N P	Styes: Y N P	Vision Problems: Y N P

Mouth/Throat/Neck:

Cavities: Y N P	Goiter: Y N P	Problems speaking: Y N P
Dentures: Y N P	Gum Disease: Y N P	Problems tasting: Y N P
Sores: Y N P	Sore throat: Y N P	Problems swallowing: Y N P
Neck Stiffness: Y N P	Swollen Glands: Y N P	

Respiratory:

Asthma: Y N P	Cough: Y N P	Shortness of Breath: Y N P
Emphysema: Y N P	TB: Y N P	Wheezing: Y N P
Pneumonia: Y N P	Bronchitis: Y N P	Pain with Breathing: Y N P

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Cardiovascular:

Palpitations: Y N P	Heart Attack: Y N P	High Blood Pressure: Y N P
Chest Pain: Y N P	Rheumatic Fever: Y N P	Arrhythmias: Y N P
Murmurs: Y N P	Edema: Y N P	Blood Clots: Y N P

Urinary Tract:

Incontinence: Y N P	Kidney Stones: Y N P	Frequent Infections: Y N P
Urgency: Y N P	Blood in Urine: Y N P	Pain with Urination: Y N P

Gastrointestinal:

Heartburn: Y N P	Vomiting: Y N P	Change in Appetite: Y N P
Indigestion: Y N P	Ulcers: Y N P	Gall Bladder Disease: Y N P
Gas/Bloating: Y N P	Hemorrhoids: Y N P	Pancreatitis: Y N P
Constipation: Y N P	Liver Disease: Y N P	Stomach Pain: Y N P
Diarrhea: Y N P	Nausea: Y N P	

Male Genitalia:

STD's Y N P	Hernia: Y N P	Erectile Dysfunction: Y N P
Discharge: Y N P	Prostate disease: Y N P	Testicular Pain/swelling: Y N P
Pain: Y N P	Sexually Active: Y N P	Frequent Night urination: Y N P

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Female Genitalia:

Age of First Menses: ___________ First Day of Last Menses: __________ Length of Menses: ________

Age of Menopause: ___________ Birth control previously or currently used: _________________________

Times Pregnant: __________ Children: _________ Miscarriages: _________ Abortions: ___________

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Abnormal Paps: Y N P	Discharge: Y N P	Pain with intercourse: Y N P
PMS: Y N P	Odor: Y N P	Healthy Libido: Y N P
STD: Y N P	Heavy Bleeding: Y N P	Sexually Active: Y N P
Vaginitis: Y N P	Vaginal Dryness: Y N P	Menstrual Cramping: Y N P

Musculoskeletal:

Weakness: Y N P	Tremors: Y N P	Leg Cramps: Y N P
Stiffness: Y N P	Arthritis: Y N P	Pain: Y N P

Nervous:

Paralysis: Y N P	Sciatica: Y N P	Numbness/Tingling: Y N P
Seizures: Y N P	Fainting: Y N P	Carpel Tunnel: Y N P

Mental/Emotional:

Depression: Y N P	Suicidal: Y N P	Psych Hospitalization: Y N P
Anxiety: Y N P	Fear/Panic: Y N P	Bipolar: Y N P
Eating Disorder: Y N P	Irritability: Y N P	Obsessive: Y N P

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Consent for Human Chorionic Gonadotropin (HCG) Weight-Loss Program

I , ____, request and consent to Injections of HCG and strict dietary restrictions for the purpose of losing weight. I understand that as part of the program I will be given a limited physical and orientation to the program, will be instructed on how to administer the injections myself or make arrangements to have someone do so. I understand that initial blood tests will be performed to rule out any conditions that would disqualify me from the program or require any prior treatment before starting the program. I agree to immediately report any problems that might occur to the medical provider during the treatment program. I further understand that there could be risks involved as there are with all medications and that not complying with the dosage recommendations and dietary restrictions could increase risks and alter the results.

I understand that HCG is **not** FDA approved for weight loss. I also understand that there is no medical evidence to support use of HCG for this purpose. The FDA requires the following statement; "HCG has not been demonstrated to be effective adjunctive therapy in the treatment of obesity. There is no substantial evidence that it increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or "normal" distribution of fat, or that it decreases the hunger and discomfort associated with calorie-restricted diets."

Patient responsibility: If you miss a scheduled appointment, it will be your responsibility to call our office to reschedule.

REFUND POLICY: Once labs are done, the physical is performed, and the treatment is started, we cannot honor any refund requests based on scheduling conflicts, missed doses, unsatisfactory results, other conflicting medical opinions, other health problems that might concurrently arise, or any other reasons.

I have read and understand all of the above. I fully understand what I am signing and hereby request and consent to Anti- Aging/weight-loss treatment using injections of HCG.

Patient Signature____ Date:__________

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Photo Release

I hereby grant Desert Wellness Center permission to use my likeness in a photograph in any and all of its publications, including website entries, without payment or any other consideration. These photographs will be cropped in such a way that my face will not be displayed in its entirety, and I will not be identifiable as the subject of the photograph. I understand and agree that these materials are the property of Desert Wellness Center and I may request a copy of the photographs.

I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge Desert Wellness Center from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 21 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

______________________________ ______________________________

(Signature) (Date)

______________________________ ______________________________

(Printed Name) (Date)

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (PLEASE PRINT):

Name:_______________________________________ Date of Birth:________________

Address: ____

City:_________________________ State:________________________ Zip:____________

Phone #:____

RELEASE MY MEDICAL RECORDS FROM:

Doctor's Name:____

Address:____

Phone #:____

Fax #:____

RELEASE MY MEDICAL RECORDS TO:

Dr. Courtney Cronin, NMD
Desert Wellness Center
2133 E. Warner Rd, #102
Tempe, Az 85284

Phone: (480) 820-6695
Fax: (480) 820-6696

Please release a copy of all my medical records, including but not limited to, progress notes, operative reports, laboratory results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient or Representative:___________________________________ Date:___________

Relationship to the Patient: _________________________________

NOTICE OF PRIVACY PRACTICES

To Our Patients: 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 (HIPPA).

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 you prevent the threat.
5. If you are a member of US 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 Worker 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 at 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 care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of 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 Desert Wellness

Center, 2133 E. Warner Rd., #102 Tempe, Az 85284. *We must respond to this request within 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 submitted in writing to Desert Wellness Center, 2133 E. Warner Rd., #102 Tempe, Az 85284. You must provide us with a reason that supports your request for amendment. *We must respond within 60 days. 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 f Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact the front desk receptionist.
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 the Office Manager at Desert Wellness Center. All complaints must be submitted in writing. You will not be penalized for submitting 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 privacy policies, please contact the Office Manager at Desert Wellness Center.