



# 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: \_\_\_\_\_

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

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Patient or legally authorized individual signature

Date

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Printed Name if signed on behalf of the patient

Relationship to patient



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### Pediatric Initial Intake

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Sex: M F Grade in School: \_\_\_\_\_ Are both Parents actively involved in child's life: Y N

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Allergies to Food or Medication:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Names of Pediatricians seen: \_\_\_\_\_

Date of Last:

Doctor's visit: \_\_\_\_\_ Blood work: \_\_\_\_\_ Dental Exam: \_\_\_\_\_ Eye Exam: \_\_\_\_\_

Current Medications and supplements (include dosage): \_\_\_\_\_  
 \_\_\_\_\_

Previous Hospitalizations and surgeries (include date): \_\_\_\_\_  
 \_\_\_\_\_

Family History:

<u>Family Member</u>	<u>Age if Living</u>	<u>Age of Death</u>	<u>Reason of Death</u>
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

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

**Vaccination History:**

Please indicate if Yes (Y), No (N) or had Some (S):

MMR: Y N S Hemophilis (Hib): Y N S DPT: Y N S  
 Polio: Y N S Chicken Pox: Y N S Hepatitis B: Y N S

Other Vaccinations: \_\_\_\_\_



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**Pregnancy History:**

Mother's age at conception: \_\_\_\_\_ Length of Labor: \_\_\_\_\_ Child's Health at Birth: \_\_\_\_\_  
 Prior Pregnancies: Y N Alcohol: Y N Recreational Drugs: Y N  
 Smoking: Y N Preeclampsia: Y N Vaginal Birth: Y N  
 Gestational Diabetes: Y N Complications of Pregnancy: \_\_\_\_\_

**Previous Medical History:**

Child Breast Fed: Y N For how long: \_\_\_\_\_ Age when Formula: \_\_\_\_\_  
 Type of Formula: \_\_\_\_\_ When were they put on solid food: \_\_\_\_\_  
 Walk: \_\_\_\_\_ Talk: \_\_\_\_\_ Teeth: \_\_\_\_\_ First Menses: \_\_\_\_\_  
 How many times has the child been on Antibiotics: \_\_\_\_\_

**Review of Systems (Younger Children)**

Indicate yes (Y), No (N), or passed (P):

Jaundice	Y	N	P	Cradle Cap	Y	N	P	Eczema/Psoriasis	Y	N	P
Diarrhea	Y	N	P	Constipation	Y	N	P	Finicky Eater	Y	N	P
Poor teeth	Y	N	P	Chronic Sniffles	Y	N	P	Bad Feet Odor	Y	N	P
Very Sweaty	Y	N	P	Growing Pains	Y	N	P	Hyperactivity	Y	N	P
Colic	Y	N	P	Bed wetting	Y	N	P	Early Puberty	Y	N	P
Anemia	Y	N	P	Tantrums	Y	N	P	Stomach Aches	Y	N	P
Asthma	Y	N	P	Disobedient	Y	N	P	Abnormal Vision	Y	N	P
Warts	Y	N	P	Fears/phobia	Y	N	P	Abnormal Hearing	Y	N	P
Nightmares	Y	N	P	Diaper Rash	Y	N	P	Abnormal Speech	Y	N	P
Ear Infections	Y	N	P	Strep Throat	Y	N	P	Learning Problems	Y	N	P

**Review of Systems (Older Children)**

Skin rash	Yes	No	Swollen Glands	Yes	No	Nausea	Yes	No
Hives	Yes	No	Problems Speaking	Yes	No	Gas/Bloating	Yes	No
Warts	Yes	No	Asthma	Yes	No	Constipation	Yes	No
Headaches	Yes	No	Pneumonia	Yes	No	Diarrhea	Yes	No
Head Injury	Yes	No	Cough	Yes	No	Stomach Pain	Yes	No
Nose Bleeds	Yes	No	Bronchitis	Yes	No	Leg Cramps	Yes	No
Allergies/Congestion	Yes	No	Shortness of Breath	Yes	No	Muscle Aches	Yes	No
Frequent Colds	Yes	No	Wheezing	Yes	No	Seizures	Yes	No
Dry/Red/Itchy Eyes	Yes	No	Murmurs	Yes	No	Fainting	Yes	No
Styes	Yes	No	Chest Pain	Yes	No	Depression	Yes	No
Vision Problems	Yes	No	Rheumatic Fever	Yes	No	Anxiety	Yes	No
Cavities	Yes	No	Urinary Infections	Yes	No	Eating Disorder	Yes	No
Canker Sores	Yes	No	Kidney Stones	Yes	No	Obsessive	Yes	No
Gum Disease	Yes	No	Heartburn	Yes	No	ADD/ADHD	Yes	No

**Please Describe a Typical Meal**

Breakfast	Lunch	Dinner

Snacks: \_\_\_\_\_ Beverages: \_\_\_\_\_



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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  
44480 W. Honeycutt Rd, #107  
Maricopa, Az 85238

Phone: (520) 431-1080  
Fax: (520) 423-3001

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: \_\_\_\_\_



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## 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



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Center, 44480 W. Honeycutt Rd., #107 Maricopa, Az 85138. *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, 44480 W. Honeycutt Rd., #107 Maricopa, Az 85138. 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 of 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.