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

2133 E Warner Rd., #102
Tempe, Az 85284

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

www.DesertWellnessCenter.com
info@DesertWellnessCenter.com

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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:

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	
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
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: _____

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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

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.