The Prevention Center
For Heart & Brain Health

BaleDoneen METHOD®
Arterial Health...for Life.

Thank you for your interest in **The Prevention Center for Heart & Brain Health.**

Our focus is simple – PREVENTION & WELLNESS. Our evidence-based approach (The BaleDoneen Method) provides the opportunity for you to avoid the devastating effects of a heart attack, ischemic stroke, type 2 diabetes, vascular dementia, and other chronic diseases. We are dedicated to optimal wellness through a paradigm of individualized care. Cardiovascular disease remains the leading cause of death and disability in this country. Type 2 diabetes is the fastest growing disease in young men and women.

We welcome you to The Prevention Center. The BaleDoneen Method is quickly being adopted around the country as the premier program for CVD prevention. Our method of cardiovascular disease prevention has been proven to stabilize vascular disease and prevent heart attacks, ischemic strokes and in many cases prevent type 2 diabetes.

As a patient at this center, you will receive personalized preventative medical care. This approach is founded on the value of precision medicine, truly making your health and wellness our top priority. Please note that this is a specialty clinic devoted to prevention. We are not a replacement for your current health care providers. We strive to work in partnership with your current health care team

We certainly look forward to meeting you and working with you. Our goal is to provide you the necessary evaluation and treatment to meet your health care goals, achieve optimal vascular health, and enjoy the quality of life you deserve.

In good health and wellness,

A. Doneen DNP ARNP

Amy L. Doneen, DNP, ARNP
Medical Director

Pierre P. Leimgruber, MD, FACC

Brea A. Seaburg

Brea Seaburg, DNP, ARNP

371 E. 5th Avenue | Spokane, WA 99202 | Phone: (509) 747-8000 | Fax: (509) 747-8051 | www.preventioncenter.health

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General Information

We are pleased you have taken this step to take a proactive role in your health with The Prevention Center. Please read through the forms carefully. Once you have completed and returned the appropriate forms to our office we will call to schedule your appointment. Included is a release for medical records form. We need to receive this form as soon as possible to allow for adequate time to request and obtain your medical records so that we can thoroughly prepare for your visit.

Although we are a "fee for service clinic," after each office visit we will provide you with a universal claim form to submit to your insurance for possible reimbursement. Be familiar with your medical plan as the possibility of reimbursement varies greatly between insurance companies and individual plans. NOTE: Claim forms CANNOT be submitted to Medicare as this is a non-contracted center. ____(Initial)

Membership with The Prevention Center is renewed annually. Please make sure to review our Pricing model and our Continuation of Care forms. If you have additional questions, please contact our office prior to your appointment. Prices are subject to change. ____(Initial)

Laboratory testing is an integral part of our risk assessment. Be aware that individual coverage may vary. It is the patient's responsibility to be familiar with their plan. The Prevention Center is NOT CONTRACTED with any lab or insurance companies. Lab fees are outside of our control. You will submit your insurance cards directly to the lab when you have your labs drawn. Also, please bring your current insurance card with you to your appointment as we do provide outside facilities with this information so they can begin the billing process for laboratory or other testing. NOTE: Lab costs are separate from the fee for the Initial Risk Assessment and all continued care. ____(Initial)

We require 4 to 6 weeks notice if you are unable to keep your Initial Risk Assessment appointment. ____(Initial)

We appreciate 48 hour notice if you are unable to keep a scheduled continuing care appointment. ____(Initial)

We accept cash, check, Visa, MasterCard and American Express.

We are located at 371 E. 5th Avenue. If you require driving directions, please contact our office at 509-747-8000.

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Patient Understanding of Initial Risk Assessment Payment

The total fee of your comprehensive risk assessment and delivery of management plan is: $4000

At the time your appointment is set, a non-refundable deposit of $500 is due to hold your appointment. Your $500 deposit applies towards your total risk assessment fee.

Your balance ($3500) is due in our office two (2) weeks prior to your appointment date. If you send payment by check, we will hold your check (it will not be deposited) or if paying by credit card, we will not run your credit card payment until 2 weeks prior to your appointment.

We accept checks and all major credit or debit cards.

Please make your checks payable to: The Prevention Center

Please mail your checks to: The Prevention Center
371 E. 5th Avenue
Spokane, WA 99202

NOTE: If you choose to use a credit or debit card for payment, please call the office with the card number, expiration date and code on the back of the card.

If you have any questions regarding billing or payments, please contact Karen at (509) 747-8000 or, preferably, karen@baledoneen.com

Name_____
Please Print

Signature_____

Date_____

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Continuation of Care Pricing - 2024

Continuing Care Patients will receive the following:

- Regular visits with labs prior to each visit for the remainder of 2024 as determined by Dr. Doneen, Dr. Leimgruber or Dr. Seaburg.
- "Continuing Care" appointments are 1-hour appointments and can be in person or by phone or Zoom.
- Although regular visits and labs will be set up, every patient has unlimited appointments available for the remainder of 2024 as needed.
- Medications are followed and ordered with any pre-authorizations as needed.
- Dietician & lifestyle coaching including genetically driven food plans & special classes for weight loss, brain health, insulin resistance & others.
- 24-hour / 7 day-a-week phone/email access to one of our providers, (509) 413-0447. **NOTE:** If you text please include your name.
- You are considered a patient until the end of 2024.

NOTE: Continuing Care fee is $315 per month. Membership fees may be paid monthly by credit card, quarterly, or annually per your preference. You may also choose to have automatic credit card payment plans as meets your needs.

Signature of Patient or Personal Representative

Date

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2024 Demographics

Date _____ Male ☐ Female ☐ _____ ☐

Name _____
Last *First* *Middle Initial*

Date of Birth _____ Social Security Number _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Mailing Address _____

City _____ State _____ Zip _____

Marital Status S ☐ M ☐ D ☐ W ☐

Physical/Secondary Address _____ City _____

State _____ Zip _____ Date From _____ to _____

Spouse/Emergency Contact _____

Phone Number _____ Emergency Contact Relationship _____

Primary Insurance Company _____

ID Number _____ Group Number _____

Secondary Insurance Company _____

ID Number _____ Group Number _____

Person Responsible for Bill _____

Signature _____

PLEASE INCLUDE A COPY(S) OF YOUR INSURANCE CARDS

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2024 Physician/Provider Information Form

Patient's Name _____ DOB_____
Last name First Middle Initial

Your primary care provider:_____

Specialty:_____ ☐ Please share labs and visit notes with this provider

Last visit:_____ Frequency of visits:_____

Telephone:_____ Fax:_____

Address:_____

Dental provider:_____

Specialty:_____ ☐ Please share labs and visit notes with this provider

Last visit:_____ Frequency of visits:_____

Telephone:_____ Fax:_____

Address:_____

Other attending provider:_____

Specialty:_____ ☐ Please share labs and visit notes with this provider

Last visit:_____ Frequency of visits:_____

Telephone:_____ Fax:_____

Address:_____

Other attending provider:_____

Specialty:_____ ☐ Please share labs and visit notes with this provider

Last visit:_____ Frequency of visits:_____

Telephone:_____ Fax:_____

Address:_____

Other attending provider:_____

Specialty:_____ ☐ Please share labs and visit notes with this provider

Last visit:_____ Frequency of visits:_____

Telephone:_____ Fax:_____

Address:_____

The Prevention Center
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Notice of Privacy Practices

January 1, 2024

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal medical provider or others working this office. This notice will inform you about the ways we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

Make sure that health information that identifies you is kept private.
Give you this notice of our legal duties and privacy practices with respect to health information.
Follow the terms of the Notice of Privacy Practices that is currently in effect.

How we may use and disclose health information about you:

For treatment, for payment, for health care operations, for appointment reminders, as required by law, public health risks, health oversight activities, lawsuits and disputes, law enforcement, coroners, health examiners and funeral directors, to avert a serious threat to health and safety, as required by the military or veterans administration, national security, inmates, workers' compensation.

Your rights regarding health information about you:

Right to inspect and copy, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice.

Changes to Notice of Privacy Practices:

We reserve the right to change this notice. We will post a copy of the current notice in our facility with the current effective date.

Complaints:

If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing.

Acknowledgment of Receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgment will become part of your records.

Patient Signature_____ Date_____ DOB_____

The Prevention Center
For Heart & Brain Health

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Patient Records of Disclosures

Acknowledgement of Review of Notice of Privacy Practices

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner.
(Please √ in each section)

Patient's Name: _____ DOB: _____
Last *First* *Middle Initial*

Preferred method of communication: _____

☐ Home Telephone: _____
- ☐ Leave message with detailed information
- ☐ Leave message with a call-back number
- ☐ Do not leave a message

☐ Work Telephone: _____
- ☐ Leave message with detailed information
- ☐ Leave message with a call-back number
- ☐ Do not leave a message

☐ Cell Telephone: _____
- ☐ Leave message with detailed information
- ☐ Leave message with a call-back number
- ☐ Text Message
- ☐ Do not leave a message

☐ Fax Number:_____
- ☐ Please do not fax any information to me

☐ Email:_____
- ☐ Please do not email any information

☐ Written Communication:
- ☐ Mail to my home
- ☐ Mail to my work/office
- ☐ Do not mail

The following people may have access to my medical information:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ Nobody

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

_____ _____
Signature of Patient or Personal Representative Date

The Prevention Center
For Heart & Brain Health

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Private Medicare Contract / Non-Contracted Form

Patient Name: _____

Patient DOB: _____

Date:_____

- I, Amy L. Doneen, DNP, ARNP, am not a contracted provider for Medicare.
- I the Medicare beneficiary or my legal representative accept full responsibility for payment of charges for all services furnished by Amy L. Doneen, DNP, ARNP. Initial_____
- I the Medicare beneficiary or my legal representative understand that Medicare limits do not apply to what Amy L. Doneen, DNP, ARNP may charge for items or services furnished. Initial_____
- I the Medicare beneficiary or my legal representative agree not to submit a claim to Medicare or to ask Amy L. Doneen, DNP, ARNP to submit a claim to Medicare. Initial_____
- I the Medicare beneficiary or my legal representative understand that Medicare payment will not be made for any items or services furnished by Amy L. Doneen, DNP, ARNP that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted. Initial_____
- I the Medicare beneficiary or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that the I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out. Initial_____
- The expected or known effective date and expected or known expiration date of the opt-out period is October 2023 (effective date) and October 2025 (expiration date).
- I the Medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare. Initial_____
- This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)
- I the Medicare beneficiary or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract. Initial_____
- I, Amy L. Doneen, DNP, ARNP will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.
- I, Amy L. Doneen, DNP, ARNP will supply CMS with a copy of this contract upon request.
- I, Amy L. Doneen, DNP, ARNP understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

_____ _____
Provider's Signature Date

_____ _____
Patient's Signature Date

_____ _____
Patient's Legal Representative Signature Date

_____ _____
Witness Date

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Private Medicare Contract / Non-Contracted Form

Patient Name: _____

Patient DOB: _____

Date:_____

- I, Pierre P. Leimgruber, MD, FACC, am not a contracted provider for Medicare.
- I the Medicare beneficiary or my legal representative accept full responsibility for payment of charges for all services furnished by Pierre P. Leimgruber, MD, FACC. Initial_____
- I the Medicare beneficiary or my legal representative understand that Medicare limits do not apply to what Pierre P. Leimgruber, MD, FACC may charge for items or services furnished. Initial_____
- I the Medicare beneficiary or my legal representative agree not to submit a claim to Medicare or to ask Pierre P. Leimgruber, MD, FACC to submit a claim to Medicare. Initial_____
- I the Medicare beneficiary or my legal representative understand that Medicare payment will not be made for any items or services furnished by Pierre P. Leimgruber, MD, FACC that would have otherwise been covered by Medicare if there was no private contact and a proper Medicare claim had been submitted. Initial_____
- I the Medicare beneficiary or my legal representative enter into this contract with the knowledge that i have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out. Initial_____
- The expected or known effective date and expected or known expiration date of the opt-out period is March 2023 (effective date) and March 2025 (expiration date).
- I the Medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for Medicare. Initial_____
- This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/ practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)
- I the Medicare beneficiary or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract before items or services are furnished to me under the terms of this contract. Initial_____
- I, Pierre P. Leimgruber, MD, FACC will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.
- I. Pierre P. Leimgruber, MD, FACC will supply CMS with a copy of this contract upon request.
- I, Pierre P. Leimgruber, MD, FACC understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

_____ _____
Provider's Signature Date

_____ _____
Patient's Signature Date

_____ _____
Patient's Legal Representative Signature Date

_____ _____
Witness Date

The Heart Attack & Stroke Prevention Center
Breaking ground with the Bale/Doneen Method

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Private Medicare Contract / Non-Contracted Form

Patient Name: _____

Patient DOB: _____

Date:_____

- I, Brea Seaburg, ARNP, DNP, am not a contracted provider for Medicare.
- I the Medicare beneficiary or my legal representative accept full responsibility for payment of charges for all services furnished by Brea Seaburg, ARNP, DNP. Initial_____
- I the Medicare beneficiary or my legal representative understand that Medicare limits do not apply to what Brea Seaburg, ARNP, DNP may charge for items or services furnished. Initial_____
- I the Medicare beneficiary or my legal representative agree not to submit a claim to Medicare or to ask Brea Seaburg, ARNP, DNP to submit a claim to Medicare. Initial_____
- I the Medicare beneficiary or my legal representative understand that Medicare payment will not be made for any items or services furnished by Brea Seaburg, ARNP, DNP that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted. Initial_____
- I the Medicare beneficiary or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that the I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out. Initial_____
- The expected or known effective date and expected or known expiration date of the opt-out period is April 2023 (effective date) and April 2025 (expiration date).
- I the Medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare. Initial_____
- This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)
- I the Medicare beneficiary or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract. Initial_____
- I, Brea Seaburg, ARNP, DNP will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.
- I, Brea Seaburg, ARNP, DNP will supply CMS with a copy of this contract upon request.
- I, understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

_____ _____
Provider's Signature Date

_____ _____
Patient's Signature Date

_____ _____
Patient's Legal Representative Signature Date

_____ _____
Witness Date

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Authorization Release for Medical Information

(Please provide a separate form for EACH provider)

Patient's Name: _____
Last *First* *Middle Initial*

DOB: _____

Address: _____

City: _____ State _____ Zip: _____

Home Phone:_____ Cell Phone:_____

I hereby authorize (Doctor's Name):_____

Address: _____

City/State/Zip: _____

Phone Number:_____ Fax Number:_____

To release my medical records to:
The Prevention Center
371 E. 5th Avenue Spokane, WA 99202
Phone: 509-747-8000 Fax: 509-747-8051

Please send the following information:

- Most recent complete physical exam
- Laboratory tests (last 2 years)
- Most recent chest x-ray, EKG, stress test, any cardiovascular tests
- Consultation reports from specialists concerning diabetes or cardiovascular disease (last 2 yrs)
- Medication list
- Chart notes (last 2 years)

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus) and other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. This authorization is given pursuant to Washington law RCW70.24 et seq.

I hereby release (Medical Provider's Name)_____and staff from all legal responsibility that may arise from the act hereby authorized.

Patient's Signature: _____ Date: _____

Guardian/Legal Representative: _____ Date: _____

To be valid, this authorization must be dated within 90 days of the request for the information and can be revoked at any time, providing that the information has not yet been released. No information for medical treatment received after the date of this authorization will be release

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Authorization Release for Dental Information

(Please provide a separate form for EACH provider)

Patient's Name: _____
Last *First* *Middle Initial*

DOB: _____

Address: _____

City: _____State _____Zip: _____

Home Phone:_____Cell Phone:_____

I hereby authorize (Dentist's Name):_____

Address: _____

City/State/Zip: _____

Phone Number:_____ Fax Number:_____

To release my dental records to:
The Prevention Center
371 E. 5th Avenue Spokane, WA 99202
Phone: 509-747-8000 Fax: 509-747-8051

Please send the following information:

- Chart notes
- Probe chart
- Pathogen testing
- Cone beam results
- *NO x-rays/We cannot accept CD's*

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus) and other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. This authorization is given pursuant to Washington law RCW70.24 et seq.

I hereby release (Dental Provider's Name):_____and staff from all legal responsibility that may arise from the act herby authorized.

Patient's Signature: _____ Date: _____

Guardian/Legal Representative: _____ Date: _____

To be valid, this authorization must be dated within 90 days of the request for the information and can be revoked at any time, providing that the information has not yet been released. No information for medical treatment received after the date of this authorization will be released.

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Health History

Name: _____ Date: _____ Date of birth: _____

How did you find out about the practice?_____

Your answers will give us a better understanding of your medical concerns and conditions. If you are uncomfortable with any questions, feel free not to answer them. Best estimates are fine; however, be specific whenever you can. Please contact family members if you need assistance completing the family history section. If you need more space, simply attach as many additional pages as you need. ***Thank you!***

How would you rate your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current age:_____ Weight :_____ Height: _____ Ethnicity: _____

Waist measurement: _____ Date of your last physical exam:_____

Medications: Please list all prescription and non-prescription medications, vitamins, home remedies, and herbs.

Medication/Supplements	*Dose (mg per pill, doses per day)*	*Start date*	*Reason*

Blood type _____

Allergies or reactions to medicines: _____

_____

_____

When was your most recent:

Cholesterol screening _____

Chest X-ray _____

Lung function _____

Colonoscopy _____

Endoscopy (upper GI) _____

Peripheral Vascular Disease test (ABI) _____

EKG _____

IMT _____

Bone density test _____

Flu vaccine _____

Shingles vaccine _____

Pneumovax _____

Covid Vaccine Brand: _____ Date(s): First Dose: _____ Second Dose: _____

Dental exam _____

Eye exam _____

Coronary CT Scan _____

Any other vascular test (Please specify) _____

_____

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Name: _____ DOB_____

Health History

Personal medical history

Please indicate whether you have had any of the following medical problems
(Include dates to indicate when the problem occurred.)

Heart Disease	☐	Root Canal	☐
Stroke	☐	Bleeding gums	☐
High Cholesterol	☐	Gout	☐
High blood Pressure	☐	Polycystic Ovaries	☐
Pre-diabetes	☐	Thyroid problems	☐
Diabetes	☐	Depression	☐
Mini-Stroke or TIA	☐	Suicide attempts	☐
Atrial Fibrillation	☐	Anxiety/Panic Attacks	☐
Poor blood flow to extremities	☐	Migraine Headaches	☐
Poor blood flow to intestines	☐	Thin Bones/osteoporosis	☐
Poor blood flow to kidneys	☐	Stomach Ulcers	☐
Aortic Aneurysm	☐	Chronic Heartburn	☐
Brain aneurysm	☐	Restless legs	☐
Bleeding/clotting problems	☐	Sleep disorder	☐
Blood transfusions	☐	Hormone imbalance	☐
Anemia	☐	Toxin Exposure	☐
High red blood cell count	☐	Unexplained Nerve Problems	☐
Leukemia	☐	Cancer	☐
Abnormal platelet count	☐	Physical disability	☐
Heart Arrhythmia	☐	Mental disability 1	☐
Heart Valve Problem	☐	Mental disability 2	☐
Rheumatoid Arthritis	☐	Post-traumatic stress syndrome	☐
Kidney disease	☐	Celiac Disease	☐
Kidney stones	☐	Diverticulosis	☐
Gallbladder stones	☐	Irritable Bowel Syndrome	☐
Pancreatic disease	☐	Gluten Intolerance	☐
Fatty liver	☐	Blood clot in legs	☐
Lupus	☐	Hodgkin's Disease	☐
Psoriasis	☐	History Hepatitis	☐
Sjögren's Syndrome	☐	Alcoholism	☐
Autoimmune disorder	☐	Drug use	☐
Periodontal Disease	☐	History AIDS	☐
Dental infections	☐		

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Health History

Name: _____ DOB_____

Have you ever been hospitalized for illness? ☐ Yes ☐ No
If so, when and why:

_____
_____
_____

Surgical history

Please list all other operations with the dates when they occurred.

_____
_____
_____
_____
_____
_____

Social history

Tobacco use

Cigarettes: ☐ Never ☐ Quit: date you quit smoking _____ ☐ Current smoker: (packs per day) _____
Other tobacco (check all answers that apply): ☐ Pipe ☐ Cigar ☐ Chewing tobacco ☐ e-cigarettes ☐ Marijuana
Number of years you've used this tobacco _____
Are you interested in quitting? ☐ Yes ☐ No Have you tried to quit in the past? ☐ Yes ☐ No
How many times have you tried to quit?_____ What methods have you tried?_____
Are you exposed to second-hand smoke? ☐ Yes ☐ No If yes, for how long? _____

Alcohol use

Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks do you consume per week? _____ Alcohol type _____

Does your alcohol consumption have you or others concerned? ☐ Yes ☐ No

Other concerns

Caffeine intake
Coffee _____ cups/day Tea _____ cups/day Sodas per day _____ ☐ Diet ☐ Regular
Chocolate _____ ounces per day (Check one.) ☐ Dark ☐ Light
Do you drink energy drinks or take pills to stay awake? ☐ Yes ☐ No If yes, specify_____
Decaffeinated products? ☐ Yes ☐ No If yes, specify / how much_____

Weight

Are you satisfied with your weight? ☐ Yes ☐ No What is your goal weight?_____
When did you last weigh your goal weight?_____ How long were you at that weight? _____

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Health History

Name: _____ DOB_____

Exercise

Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise? _____

How long do you exercise in minutes? _____ How often? _____

If you do not exercise, why not? _____

Do you have any limitations to your ability to exercise? Please explain_____

Socioeconomics

Occupation _____

Employer _____

Years of education/highest degree _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse/partner's name _____

Who lives at home with you?_____

How many children do you have? (Please provide names, gender, and ages.)_____

_____

Where were you born?_____ Where did you grow up?_____

Where do you live now and for how long?_____

Oral Health:

How many times per day do you brush your teeth?_____ What type of toothbrush do you use?_____

Do you floss regularly? ☐ Yes ☐ No How often? _____

How often do you see your dentist?_____ Do you ever have bleeding gums? ☐ Yes ☐ No

Does your oral health concern you? ☐ Yes ☐ No If yes, why?_____

Stress

How would you classify your stress level at work? (Please check one) ☐ Low ☐ Medium ☐ High

How would you classify your stress level at home? ☐ Low ☐ Medium ☐ High

Do you often feel anxious, angry, irritated or rushed? ☐ Yes ☐ No

How do you manage your stress?_____

List ways for which you relax?_____

Do you meditate daily? ☐ Yes ☐ No If yes, how?_____

Do you perceive a lack of control of your environment? ☐ Yes ☐ No If yes, why?_____

Diet

How do you rate your diet? (Please check one) ☐ Good ☐ Fair ☐ Poor

Do you currently see a dietitian? ☐ Yes ☐ No If yes, how often?_____Name and contact:

How many daily servings of the following do you have:

Whole grains	_____	Nuts	_____
Water	_____	Vegetables	_____
Fruit	_____	Milk	_____ what %_____

How many times a week do you consume the following items?

Eggs	_____	Margarine	_____
Fish	_____	Dairy Products	_____
Chicken/Turkey	_____	Fried Foods	_____
Red Meat	_____	Processed foods	_____
Butter	_____	Going out to eat	_____

Do you have any food allergies or food sensitivities? ☐ Yes ☐ No

If yes, please explain_____

Please List ALL supplements:_____

_____

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Name: _____ DOB_____

Health History

History for Men:

Do you have problems with erections? ☐ Yes ☐ No If yes, date of onset_____
Do you have problems with sexual desire or sex drive ☐ Yes ☐ No If yes, date of onset_____
Do you have problems with sexual satisfaction ☐ Yes ☐ No If yes, date of onset_____
Do you have problems with decreased energy
or decreased muscle strength ☐ Yes ☐ No If yes, date of onset_____

History for women

How many times have you been pregnant? _____ How many deliveries? _____ miscarriages? _____
Please list any problems you have experienced with pregnancy or delivery: _____

Do you have osteoporosis (bone loss)? ☐ Yes ☐ No osteopenia (bone thinning)? ☐ Yes ☐ No

When was the first day of your most recent period?_____ What was your age at your first period? _____
Frequency of periods_____ Length of each_____ (Check one) ☐ Regular ☐ Irregular

Menopause? ☐ Yes ☐ No
Hysterectomy? ☐ Yes ☐ No When _____ Ovaries removed? ☐ Yes ☐ No

Do you have any history of gestational diabetes? ☐ Yes ☐ No
High blood pressure or eclampsia with pregnancy? ☐ Yes ☐ No

Did any of your children weigh more than eight pounds at birth? ☐ Yes ☐ No

Do you have problems with sex drive? ☐ Yes ☐ No If yes, date of onset_____
Do you have problems with sexual satisfaction? ☐ Yes ☐ No If yes, date of onset_____

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Name: _____ DOB_____

Health History

Travel History:

Any recent International Travel? ☐ Yes ☐ No

If yes, What Countries and dates of stay_____

Any illnesses during or post travel? _____

Review of symptoms

Please check any current problems you have on the list below.

Constitutional:
- ☐ Fever/chills/sweats
- ☐ Unexplained weight loss/gain
- ☐ Brittle nails
- ☐ Dry skin
- ☐ Change in skin texture
- ☐ Change in hair texture
- ☐ Inability to stand heat
- ☐ Inability to stand cold
- ☐ Change in energy/increased weakness
- ☐ Excessive thirst or urination
- ☐ Swelling (Explain)_____

Respiratory:
- ☐ Cough/wheeze
- ☐ Difficulty breathing
- ☐ Snoring
- ☐ Sleep apnea/CPAP Frequent
- ☐ respiratory infections

Eyes:
- ☐ Change in vision (Explain)_____
- ☐ Dry Eyes
- ☐ Frequent irritation
- ☐ History of retinal tear or hemorrhages
- ☐ Double vision
- ☐ Glaucoma (Treatment?)_____
- ☐ Cataracts (Surgery?)_____

Ear/Nose/Throat/Mouth:
- ☐ Difficulty hearing/ringing in your ears
- ☐ Hay fever/allergies
- ☐ Bleeding gums
- ☐ Dental Cavities
- ☐ Painful teeth or gums
- ☐ Bad breath
- ☐ Root canals
- ☐ Dental implants

Cardiovascular:
- ☐ Chest pain/discomfort
- ☐ Palpitations (irregular heart beats)
- ☐ Swelling in feet or legs
- ☐ Varicose veins
- ☐ Pain in extremities with exercise

Skin:
- ☐ Acanthosis nigricans (dark lines around neck or under arms)
- ☐ Skin tags
- ☐ Flattening of nail beds
- ☐ Creases in earlobes
- ☐ Frequent itching of skin
- ☐ Skin infections

Genitourinary:
- ☐ Unusual frequency of urination
- ☐ Increased urination at night that interrupts sleep
- ☐ Blood in urine

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Blood in bowel movement
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain

Neurological:
- ☐ Headaches
- ☐ Light-headedness
- ☐ Memory loss
- ☐ Loss of coordination
- ☐ Tingling, pain, or numbness in hands or feet

Psychiatric:
- ☐ Problems with sleep
- ☐ Depression
- ☐ Panic attacks
- ☐ Mania
- ☐ Anxiety
- ☐ Anger issues
- ☐ Short temper or impatience
- ☐ Unusual feeling of doom
- ☐ Suicidal thoughts
- ☐ Hopelessness and constant worry

Blood/Lymphatic:
- ☐ Easy bruising/bleeding
- ☐ Unexplained lumps
- ☐ Unusual bleeding
- ☐ Unusually pale
- ☐ Unusual ruddy appearance
- ☐ History of blood clots
- ☐ History of low platelet counts
- ☐ History of high platelet counts
- ☐ History of low white blood cell counts
- ☐ History of anemia

Muscle/Skeletal:
- ☐ Chronic joint problem
- ☐ Back problems
- ☐ Neck problems
- ☐ Spine problems
- ☐ Muscle injuries
- ☐ Arthritis
- ☐ History of bone fractures
- ☐ History of torn or ruptured tendons
- ☐ Paralysis of any muscles
- ☐ Unusual muscle weakness
- ☐ Any muscle side effects from statins

Any other symptoms? If so, please list them:

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Name: _____ DOB_____

Health History

Family history

Please indicate the current status of your immediate family members. Include if each person is alive or deceased; the person's age now or at time of death; if applicable, the cause of death; and any other relevant comments.

Mother's mother _____

Mother's father _____

Father's mother _____

Father's father _____

Mother _____

Father _____

Sister _____

Sister _____

Sister _____

Brother _____

Brother _____

Brother _____

Daughter _____

Daughter _____

Daughter _____

Son _____

Son _____

Son _____

Please use this space to list any additional family members:

_____

_____

_____

_____

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Name: _____ DOB_____

Health History

Please indicate with a check mark any family members who have had any of the following medical conditions:

Medical condition	Mom	Dad	Sister	Brother	Daughter	Son	Mom's mom	Mom's dad	Dad's mom	Dad's Dad	Mom's sister	Mom's brother	Dad's sister	Dad's brother
Heart attack														
Stroke														
Diabetes-Type 2 (adult onset)														
Alcoholism														
Anemia														
Aortic aneurysm														
Alzheimer's														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding problems														
Carotid artery disease														
Cancer														
Depression														
Diabetes-Type 1 (childhood onset)														
Other genetic disease														
High cholesterol (hyperlipidemia)														
High blood pressure (hypertension)														
Immunosuppressive disorders														
Kidney disease														
Osteoporosis														
Peripheral vascular disease														
Epilepsy (seizure disorder)														
Substance abuse														
Thyroid disorder														
Smoking														
Sleep apnea														
Polycystic overy Disease														
Coronary bypass														
Coronary stents														
Mini strokes														
Gum Disease														
Bad teeth														

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Universal Insurance Claim Form

Please send reimbursement to the patient listed below.
This form replaces HCFA. The patient has paid provider for services.

Patient instruction: *Submit a copy of your insurance card and a copy of your bill slip along with this universal insurance form to your insurance company.*

Primary insurance company _____

Primary insurance company's address

Street _____ City _____ State _____ Zip Code _____

Policy holder's last name _____ First name _____ Middle initial _____

Policy holder's birthday (month/day/year) _____

Policy holder's employer _____

Date of service _____ ID number _____ Group number _____

Patient's last name _____ First name _____ Middle initial _____

Patient's address

Street _____ City _____ State _____ Zip Code _____

Patient's home phone _____ Patient's date of birth _____

Referring physician _____ Federal Tax ID#: 20-5689694

Total fees paid out of pocket $ _____ Cash ☐ Check ☐ _____ *(Include check number)* Credit card ☐

Patient (or guardian's) Signature _____

Insurance company Please see attached encounter form for diagnosis, ICD-9 codes, and procedure codes.

Secondary insurance company _____

Secondary insurance company's address

Street _____ City _____ State _____ Zip Code _____

Secondary insurance policy holder's last name _____ First name _____ Middle initial ___

Secondary insurance policy holder's address (if different from above)

Street _____ City _____ State _____ Zip Code _____

Secondary policy holder's birthday (month/day/year) _____

ID number _____ Group number _____

Provider signature is provided on the bill slip attached to the universal claim form.