BASE CAMP
FUNCTIONAL MEDICINE

Patient Registration & Personal Health History

Dr. Jay Campbell, DO

1540 Commercial St SE
Salem OR, 97302
503.877.2125

Please fill out completely and sign in the yellow highlighted areas.

Patient Name: _____ DOB: _____

What is your preferred first name? (Nickname, Chosen name, etc.) _____

Sex: ☐ Male ☐ Female Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell phone: _____ ☐ Consent ☐ Do not consent to receive text notices of appointments and prescriptions.

*Required for insurance billing and checks

Preferred Contact Phone Number: ☐ Cell ☐ Home ☐ Work *SSN: _____

The information assists us to help you reach your health goals. (Please answer all questions.)

Occupation: _____ Hours per Week: _____

Employer: _____Address: _____

City: _____State: _____Phone: _____

Employment Status (√ one): □ Full Time □ Not Employed □ Part Time □ Retired □ Self-Employed □ Student □ Homemaker

My preferred pharmacy: _____

Primary Care Provider (PCP) Information (Please select one of the following):

☐ I wish to establish Primary Care with Dr. Jay Campbell, DO.
☐ I see Dr. Jay Campbell, DO for adjunctive care only.

My Current Primary Care Physician (PCP) is: _____

At (Clinic Name including phone number): _____
☐ I do not have a Primary Care Physician and do not wish to establish Primary Care with Dr. Jay Campbell, DO at this time.

Emergency Contact Name: _____

Relationship: _____ Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Legal Guardian? □ Yes □ No

Patient: _____ _____ _____ **Date of Birth** _____

Guarantor (Person who is financially responsible for the account):

Name: _____ Relationship to the patient: _____

Address (if different from patient): _____

City: _____ State:_____ Zip: _____

Social Security Number: _____ Gender: □ M □ F DOB: _____

Phone :_____ Email:_____

Base Camp Functional Medicine Billing Department requires that *all visits and labs be paid for at the time of service*. If you have out-of-network benefits, payment is still expected at the time of service. We still need to collect insurance information for labs and imaging studies.

Please provide your insurance information below and give your card to the receptionist to be photocopied even if you opt for time-of-service payment as this information may be submitted to the lab company if using Quest or Labcorp:

Insurance Company: _____

Claims Address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Member ID #_____ Group # _____ Subscriber ID #_____

****Please be prepared to present your insurance card at check-in at each visit and inform the office if you have had a change in coverage****
****Although Base Camp Functional Medicine is not contracted with Medicare, it is our policy to collect all coverage information****
Do you have Medicare? □ Yes □ No If "yes", is it your primary insurance? □ Yes □ No

Medicare Plan (check all that apply): □ Part A □ Part B □ Advantage (Part C)

Subscriber ID #_____ Effective Date (if known): _____

I authorize the following individual(s) to arrange appointments at Base Camp Functional Medicine on my behalf:

Name: _____ Name: _____

DOB: _____ DOB: _____

Relationship to Patient: _____ Relationship to Patient: _____

I certify the above information is true and correct to the best of my knowledge.

_____ _____

Patient or Legal Guardians Signature **Date**

Patient: _____ _____ _____ **Date of Birth** _____

Statement of Financial Responsibility:

I understand and agree to the following general responsibilities:

- Financial options are extended to me based on the information I have provided.
- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including lab work and tests.
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to initiate collections on any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Base Camp Functional Medicine to release the information necessary to secure payment.
- There will be a flat fee of $25 for any appointment that is either missed or not canceled within 48 hours of the appointment time.
- Three missed appointments will result in a severance of services.

Financial Options:

Please be aware that you do NOT have to provide your social security number as a form of personal identification to receive health care. However, in compliance with state and federal guidelines, Base Camp Functional Medicine does require your social security number before certain financial options can be extended to you. The following are financial options that can be offered if you provide your social security number:

1) If you choose to provide us with your social security number, you can choose to:
   - Make payment by cash, check, or credit card

2) If you choose to not provide us with your social security number, you may:
   - Make payment by cash or credit card only.

3) Please note: If you would like to pay by check for services rendered, you may be asked to furnish a valid state-issued identification card that shows the same address as the check you are submitting as payment.

4) Returned checks/bank card services will be subject to a 25.00 fee as specified by state law.

HIPAA Notice of Privacy Practices and Consent:

- I hereby consent to the use and disclosure of my Protected Health Information by Base Camp Functional Medicine for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.
- I have been given the opportunity to read and review a copy of Base Camp Functional Medicine's privacy practices. I have had all questions regarding these procedures answered to my satisfaction.

_____ _____ _____

Patients or Legal Guardians Signature **Date** **Relationship to Patient**

PERSONAL HEALTH HISTORY

Patient: _____ _____ _____ **Date of Birth** _____

What is the main reason for your visit today?

_____

Allergies: Do you have any allergies to the following? **(Please circle all that apply)**

Sulfa Penicillin Tetracycline Morphine Aspirin Codeine NSAIDS Latex Lidocaine Contrast Dye Sulfites Pollen

Cats Dogs Mold Dust Bee Stings Soy Wheat/Gluten Shellfish Fish Peanuts Eggs Milk

Other _____

Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking:

Name of Medication/Supplement	Strength/Dosage	Frequency	Reason for Taking

Medical Conditions: Do you currently have or have a history of the following? **(Please select all that apply)**

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Stroke

☐ Asthma ☐ COPD ☐ Diabetes ☐ Cancer

☐ Depression/Anxiety ☐ Liver Disease ☐ Digestive Problems ☐ Thyroid Disorder

☐ Adrenal Disorder ☐ Kidney Disease ☐ Other_____

Surgeries / Hospitalizations: Have you had any of the following surgeries? **(Please select all that apply)**

☐Appendectomy ☐ Brain Surgery ☐ Breast Surgery ☐ C-Section

☐ CABG ☐ Cholecystectomy ☐ Colon Surgery ☐ Cosmetic

☐ Eye Surgery ☐Fracture Surgery ☐ Hernia Repair ☐ Hysterectomy

☐ Joint Replacement ☐ Prostate Surgery ☐ Small Intestinal Surgery ☐ Spine Surgery

☐ Tonsillectomy ☐ Tubal Ligation ☐ Valve Replacement ☐ Vasectomy

☐ Bariatric Surgery for Weight Loss ☐ Other (please list below):

Patient: _____ _____ _____ **Date of Birth** _____

Family History: Do you have a family history of any of the following? **(Please "X" the boxes that apply to you)**

Medical Condition	Mom	Dad	Brothers	Sisters	Mom's Mom	Dad's Mom	Mom's Dad	Dad's Dad	Parent's Siblings
Alcohol/Drug Addiction									
Arthritis									
Asthma									
Cancer									
Heart Disease									
Depression or Anxiety									
Digestive Issues									
Diabetes									
High Cholesterol									
High Blood Pressure									
Kidney disease									
Mental Illness									
Stroke									
Vision Problems									
Other									

Depression Screen: Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things: ☐ nearly every day ☐ more than half the days ☐ several days ☐ not at all
2. Feeling down, depressed, or hopeless: ☐ nearly every day ☐ more than half the days ☐ several days ☐ not at all

Social History: Please answer the following questions regarding your social history:

Do you drink alcohol? ☐ Yes ☐ No
If "YES", how many of the following per week: ____glasses of wine _____shots of liquor _____cans of beer
Are you sexually active? ☐ Yes ☐ No ☐ Not Currently

Do you currently use, or have you used any recreational or street drugs including marijuana and E-cigs? ☐ Yes ☐ No
If yes, please specify which one(s) and how used _____
Do you use or have you used in the past any of the following tobacco products? (Please select all that apply):
☐ None ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Snuff ☐ Chew
☐ Other _____ Packs per day: _____

Start Date: _____ Years of smoking: _____

Quit Date: _____ Ready to quit? ☐ Yes ☐ No

Patient: _____ _____ _____ **Date of Birth** _____

Review of Systems: Please circle below: **Y=Yes, present condition or experienced in the last month.** **N=No, never had the condition in the last month.**								
Constitutional								
Fever	Y	N	Chills	Y	N	Weight Loss	Y	N
Malaise/Fatigue	Y	N	Sweating	Y	N	Weakness	Y	N
Skin								
Rash	Y	N	Itching/Dry Skin	Y	N	Color Changes/New Moles	Y	N
Head, Ears, Nose, Throat								
Headaches	Y	N	Hearing Loss	Y	N	Nosebleeds	Y	N
Ear Pain	Y	N	Ear Discharge	Y	N	Sore Throat	Y	N
Sinus/Nasal Congestion	Y	N	Jaw/TMJ Pain	Y	N	Seasonal Allergies	Y	N
Migraine Headaches	Y	N	Ringing in the Ears	Y	N	Facial Flushing	Y	N
Eyes								
Blurred Vision	Y	N	Double Vision	Y	N	Light Sensitivity	Y	N
Eye Pain	Y	N	Eye Discharge	Y	N	Eye Redness/Itching	Y	N
Cardiovascular								
Chest Pain	Y	N	Palpitations/Arrhythmias	Y	N	Shortness of Breath	Y	N
Claudication	Y	N	Leg Swelling/Edema	Y	N	Peripheral Artery Disease	Y	N
Abdominal Pain	Y	N	Blood Clots	Y	N	Heart Disease	Y	N
Low/High Blood Pressure	Y	N	Tachycardia	Y	N	Snoring	Y	N
Respiratory								
Cough	Y	N	Coughing up Blood	Y	N	Sputum Production	Y	N
Shortness of Breath	Y	N	Wheezing	Y	N	Asthma	Y	N
Gastrointestinal								
Heartburn	Y	N	Nausea	Y	N	Abdominal Distention/Gas	Y	N
Abdominal Pain	Y	N	Diarrhea	Y	N	Vomiting/Nausea	Y	N
Blood in Stool	Y	N	Black Tarry Stools	Y	N	Constipation	Y	N
How Many Bowel Movements a Day			_____			Mucus in Stools	Y	N
Genitourinary								
Painful Urination	Y	N	Urgency	Y	N	Frequent Urination	Y	N
Blood in Urine	Y	N	Itching	Y	N	Incontinence	Y	N
Frequent Infections	Y	N	Discharge	Y	N	Flank/Kidney Pain	Y	N
Male Reproductive								
Hernias	Y	N	Testicular Mass/Pain	Y	N	Low Libido/ED	Y	N
Female Reproductive								
Cramps w/ Menses	Y	N	Irregular Menses	Y	N	Excessive Bleeding	Y	N
Irritability with Menses	Y	N	Post-Menopausal Bleeding	Y	N	Endometriosis	Y	N
Ovarian Cysts	Y	N	Fibroids	Y	N	Amenorrhea	Y	N
Low Libido	Y	N	History of Breast Implants	Y	N	History of Surgical Mesh	Y	N
Fertility Issues	Y	N	Length of Cycles _____ Days			Duration of Menses _____Days		
Hot Flashes	Y	N	Number of Pregnancies _____			Number of Live Births _____		
Night Sweats	Y	N	Number of Miscarriages _____			Number of Abortions _____		
Date of Last Menses if Menopausal or Perimenopausal _____				Date of Last Pap Smear _____				
Musculoskeletal								
Muscle pain	Y	N	Neck Pain	Y	N	Back Pain	Y	N
Joint Pain	Y	N	Falls	Y	N	Muscle Spasms/Cramps	Y	N

Patient: _____ _____ _____ **Date of Birth** _____

Endocrine/Heme/Allergies								
Excessive Thirst	Y	N	Environmental Allergies	Y	N	Dry Skin	Y	N
Cold Intolerance	Y	N	Diabetes	Y	N	Excessive Hair Loss	Y	N
Easy Bruising/Bleeding	Y	N	Heat Intolerance	Y	N	Thyroid Issues	Y	N
Neurological	Y	N	Tingling	Y	N	Numbness	Y	N
Dizziness	Y	N	Speech Change	Y	N	Paralysis	Y	N
Sensory Change	Y	N	Fainting	Y	N	Loss of Memory	Y	N
Seizures	Y	N	Suicidal Ideas	Y	N	Substance Abuse	Y	N
Emotional (Psychiatric)	Y	N	Nervous/Anxious	Y	N	Insomnia	Y	N
Depression	Y	N	Mood Swings	Y	N	Tension/Stressed	Y	N
Hallucinations								
Memory Loss								

Informed Consent and Request for Care:

I do hereby give my consent to services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient of the Base Camp Functional Medicine.

I, _____, hereby request and consent to examination and treatment with the providers, and affiliated providers of Base Camp Functional Medicine.

I understand I have the right to ask questions and discuss to my satisfaction with the above-mentioned providers the nature and purpose of a functional medicine evaluation and treatment and other procedures which my physician may administer.

I understand that all medical procedures carry inherent risks and complications. Though rare, complications can occur. Complications from injection therapy may include pain at the site of the injection/infusion, an allergy to the injection resulting in rash, vasculitis, lightheadedness, weakness, or even anaphylaxis which may be fatal. Manipulation therapy may result in sprains, strains, dislocations, fractures, disc injury, or even cerebral vascular accidents. Complications or undesirable results from treatment do not necessarily indicate improper treatment or error on the part of the practitioner. I agree to communicate any undesirable results or side effects to my physician in a timely manner so that changes if deemed necessary, can be made to my treatment plan.

The physician will try to explain risks and complications at the time of the visit, but it is unreasonable to expect the physician to anticipate or explain every potential risk prior to a certain procedure. Pt acknowledges that the physician will exercise professional judgment which the physician feels at the time is in the best interest of the patient.

Functional medicine, as with any practice of medicine, is not an exact science but requires that the practitioner use the information gathered during the examination and interview process along with analysis of this information to reach a clinical decision. The physician will exercise his best judgment and expertise to help the patient regain health, but there is no promise implied or otherwise of a permanent cure for any symptoms, condition, or disease because of treatment by Base Camp Functional Medicine.

I have read the above-informed consent and request for care document and have had the opportunity to ask questions and receive answers on the above material. I am comfortable with the information provided and consent to a functional medical evaluation, treatment, and management.

_____

Printed Name

_____ _____ _____

Patients or Legal Guardians Signature **Date** **Relationship to Patient**

BASE CAMP
FUNCTIONAL MEDICINE

Dr. Jay Campbell, DO
1540 Commercial St SE
Salem, OR 97302
503.877.2125

Medical Records Release Form for Family or Friends

PLEASE PRINT Patient's Full Name: _____

Date of Birth:_____ Phone Number :_____

Address:_____City:_____ State:_____ Zip:_____

I hereby authorize Base Camp Functional Medicine to share records and information with:

Name: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Relationship to Patient: _____

This Authorization extends to:

o ALL RECORDS (unless specified below.)

Additionally:

o Most recent labs
o Drug/Alcohol/Substance abuse records
o Most recent Colonoscopy/Endoscopy
o Psychiatric/Mental health records
o Most recent Pap smear pathology
o HIV/STD results
o Most recent Mammogram
o Genetic Information
o Immunization Record
o OTHER _____

Duration: This authorization is effective immediately and will remain in effect for one year from the date of signature, unless a different date is specified here: _____.
The recipient of this protected health information will not re-disclose the information except with written authorization or as specifically required or permitted by law. Upon request, the patient will receive a copy of this completed authorization form. This authorization is subject to written revocation by the patient at any time. A copy of this authorization is as valid as the original.

Signature:

_____

Relationship to patient:_____Date:_____

BASE CAMP
FUNCTIONAL MEDICINE

Dr. Jay Campbell, DO
1540 Commercial St SE
Salem, OR 97302
503.877.2125

Medical Records Release Form

I hereby authorize Base Camp Functional Medicine to send records and information to:

Name: _____

Address: _____City: _____State: _____

Zip: ___ Phone: _____ Fax: _____

PLEASE PRINT Patient's Full Name: _____

Date of Birth:_____ Phone Number :_____

Address:_____City:_____ State:_____ Zip:_____

WE ARE REQUESTING:

o ONE YEAR OF COMPLETE RECORDS, unless specified below.
(Send the most recent 12 months that the patient was seen.)

Additionally:

o Most recent labs
o Drug/Alcohol/Substance abuse records
o Most recent Colonoscopy/Endoscopy
o Psychiatric/Mental health records
o Most recent Pap smear pathology
o HIV/STD results
o Most recent Mammogram
o Genetic Information
o Immunization Record
o OTHER _____

Duration: This authorization is effective immediately and will remain in effect for one year from the date of signature, unless a different date is specified here: _____. The recipient of this protected health information will not re-disclose the information, except with a written authorization or as specifically required or permitted by law. Upon request, the patient will receive a copy of this completed authorization form. This authorization is subject to written revocation by the patient at any time. A copy of this authorization is as valid as the original.

Signature: _____

Relationship to patient:_____Date:_____

Dr. Jay Campbell, DO
1540 Commercial St SE
Salem, OR 97302
Ph: (503) 877-2125
Fax: (833) 972-5671

Medical Records Release Form

I hereby authorize Base Camp Functional Medicine to receive records and information **from**:

Name: _____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Fax: _____

PLEASE PRINT Patient's Full Name: _____

Date of Birth:_____ Phone Number :_____

Address:_____City:_____ State:_____ Zip:_____

WE ARE REQUESTING:

o ONE YEAR OF COMPLETE RECORDS, unless specified below.

(Send the most recent 12 months that the patient was seen.)

Additionally:

o Most recent labs
o Drug/Alcohol/Substance abuse records
o Most recent Colonoscopy/Endoscopy
o Psychiatric/Mental health records
o Most recent Pap smear pathology
o HIV/STD results
o Most recent Mammogram
o Genetic Information
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Signature: _____

Relationship to patient:_____Date:_____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. Currently, that fee is $25.00.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
    - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
    - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

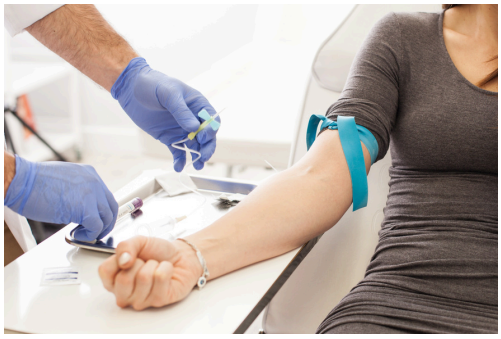
Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the back page.

Directions for Blood Draws



All blood draws must be completed by 11:30 am in order to meet cut off times for FedEx and UPS pickup times.

- If your labs are fasting: (common fasting labs include *lipid panels, fasting blood sugars* and *comprehensive metabolic panels*)
  - Please do not eat for 12 hours prior to your blood draw.
  - Please do not drink anything except for plenty of plain unflavored WATER prior to your blood draw.
  - Water does NOT include energy drinks, black coffee, tea or electrolyte supplements.
  - If you are NOT fasting, you will be rescheduled and may be charged a fee for your failed appointment.

  • Please come **WELL** hydrated. Blood draws may have to be rescheduled due to poor hydration status at the time of the blood draw. Start drinking water the night before and continue drinking water the morning of you blood draw. Your goal is a minimum two quarts. One the night before and one the morning of your blood draw. If you are unsure if your labs are fasting or not it is best to come fasting to ensure that your do not have to be rescheduled.

- If your labs include a check of endocrine hormones, please do not take them the day of your test. This includes:
  - *Thyroid hormones.*
  - *Hydrocortisone*
  - Oral sex hormones such as *progesterone, estrogen or testosterone*.
  - If you are injecting hormones, please skip any injections that are within four days of your blood draw.

- If checking *PSA* (prostate specific antigen) no intercourse for three days prior to your test.

- If checking for *H-pylori* via a breath test, no eating or drinking one hour prior to your exam.

- Check with your doctor if you think one of these guidelines does not apply to you.