**Navigating Wellness Primary Care**
**50 Columbia Street #11, Suite 62**
**Bangor, ME - 04401-6331**

# 1 NWPC Adult New Patient Registration & Consent to Treat

## Navigating Wellness Primary Care Adult New Patient Registration & Consent to Treat

Name *

Date of Birth *

Gender affiliation *

Email

Phone number *

Address *

How did you hear about us (please be specific)?

Reason for office visit:

- ☐ Primary Care
- ☐ Mental Health / Medication Mangement
- ☐ Diabetes
- ☐ Thyroid
- ☐ Weight Loss
- ☐ IV Infusion
- ☐ Acne / Dermatology
- ☐ DOT exam

Please list your pharmacy (may list multiple)

**Personal and Family Medical History**

Height:

Weight:

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Do you have any of the following conditions? Please type in anything that is not listed.

- ☐ Allergies.
- ☐ Anxiety
- ☐ Arthritis and other joint and bone disorders and injuries.
- ☐ Bipolar disorder
- ☐ Diabetes.
- ☐ Depression
- ☐ Heart disease, including coronary artery disease and heart failure.
- ☐ High blood pressure.
- ☐ High cholesterol.
- ☐ Obesity.
- ☐ Skin issues, like acne or eczema.
- ☐ Substance use disorder.
- ☐ Menopause.
- ☐ Osteoporosis.
- ☐ Postpartum depression.
- ☐ Thyroid problems.
- ☐ Urinary incontinence.
- ☐ Benign prostatic hyperplasia or enlarged prostate.
- ☐ Erectile dysfunction.
- ☐ Asthma.
- ☐ Chronic bronchitis.
- ☐ COPD.
- ☐ Fibromyalgia.
- ☐ GERD.
- ☐ Stomach ulcers.
- ☐ ADHD/Autism spectrum
- ☐ Other mental health concerns

Are you currently receiving healthcare? ☐ Yes ☐ No

If yes, where and from whom?

List all allergies to medications, foods, and environment.

List all medications (from drugstore or prescription) you are taking and dosages if known:

Do you use any drugs including marijuana? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If yes, please specify:

- ☐ Rarely
- ☐ Occasionally
- ☐ Daily
- ☐ Past

How many caffeinated beverages to you consume per week?

Please list any family medical history for your biological mother

- ☐ dementia or memory problems
- ☐ cardiac disease
- ☐ vascular disease
- ☐ hypertension
- ☐ stroke
- ☐ thyroid disorder
- ☐ respiratory disease
- ☐ gastrointestinal disease
- ☐ cancer (including skin)

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Please list any family medical history for your biological father

- ☐ dementia or memory problems
- ☐ cardiac disease
- ☐ vascular disease
- ☐ hypertension
- ☐ stroke
- ☐ thyroid disorder
- ☐ respiratory disease
- ☐ gastrointestinal disease

Please list any family medical history for your siblings

- ☐ dementia or memory problems
- ☐ cardiac disease
- ☐ vascular disease
- ☐ hypertension
- ☐ stroke
- ☐ thyroid disorder
- ☐ respiratory disease
- ☐ gastrointestinal disease

CONSENT TO TREAT I understand that by signing this agreement I consent to treatment including evaluation, therapies, and diagnostic testing provided under the general or specific instruction of my health care providers, in-person or via telemedicine.

**PATIENT SIGNATURE**