Patient Registration & Personal Health History

Abigail Bisson ND
1540 Commercial St SE
Salem OR, 97302
503.581.6239

Please fill out completely and sign in the yellow highlighted areas. Thank-You!

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: _____ _____

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 is:_____

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

☐ I wish to establish Primary Care with Abigail Bisson ND.

☐ I see Abigail Bisson ND 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 Abigail Bisson ND, PC at this time.

Emergency Contact Name: _____

Relationship: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Legal Guardian? □ Yes □ No

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:_____

Abigail Bisson ND, Inc 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 time of service, but we will bill your insurance provider and reimburse you directly for your visit should we receive payment. Please be advised that the amount of the reimbursement, if any, may not coincide with the amount that you paid at the time of your visit. It is your responsibility to verify whether or not you have **out of network** benefits.

Please provide your insurance information below and give your card to the receptionist to be photocopied:

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** (insurance for □ labs only □ for both labs and office visits – Office use only)**

****Although Abigail Bisson ND, Inc. 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 Abigail Bisson ND, Inc on my behalf: (OPTIONAL)

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**

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. As a courtesy to our patients, we will bill insurances if patient has out of network benefits. These payments will be directed to the patient unless full payment has not been received by the clinic. **Abigail Bisson ND, PC offers a fifteen percent (15%) cash discount ONLY on office visits if no insurance is being billed and service is paid in full at time of service.**
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of 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 the Abigail Bisson ND, PC to release information necessary to secure payment.
- There will be a flat fee of $25 for any appointment or IV that is either missed or not canceled within 48 hours of the appointment time.
- I may forfeit the privilege of billing my insurance carrier if I do not comply with any of my financial responsibilities or documentation requirements.
- I authorize release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to the Abigail Bisson ND, PC. This release applies to support of the insurance billing process only.

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, Abigail Bisson ND, PC 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:
   - Bill health insurance (If patient has out of network benefits or is covered by Employee Benefit Management Services through the City of Salem)
   - 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 Abigail Bisson ND, Corp 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 Abigail Bisson ND, Corp'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):

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 your 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 your used in the past any of the following tobacco products? (Please select all that apply):
☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Snuff ☐ Chew
☐ Other _____ Packs per day: _____

Start Date: _____ Years of smoking: _____

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

Review of Systems: Please circle below: **Y=Yes, present condition or experienced in the last two weeks.** **N=No, have not experienced in the last two weeks.**								
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	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			
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			
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
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	Y	N

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								
Dizziness	Y	N	Tingling	Y	N	Numbness	Y	N
Sensory Change	Y	N	Speech Change	Y	N	Paralysis	Y	N
Seizures	Y	N	Fainting	Y	N	Loss of Memory	Y	N
Emotional (Psychiatric)								
Depression	Y	N	Suicidal Ideas	Y	N	Substance Abuse	Y	N
Hallucinations	Y	N	Nervous/Anxious	Y	N	Insomnia	Y	N
Memory Loss	Y	N	Mood Swings	Y	N	Tension/Stressed	Y	N

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 Abigail Bisson ND, PC.

I, _____, hereby request and consent to examination and treatment with the providers, and affiliated providers of Abigail Bisson ND, Inc.

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

I understand that all medical procedures carry inherent risks and complications. Though rare, complications can occur. Complications from injection/IV therapy including UVBI and Chelation 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 sprain, 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 judgement which the physician feels at the time is in the best interest of the patient.

Naturopathic 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 as a result of treatment by Abigail Bisson ND, Corp.

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

_____

Printed Name

_____ _____ _____

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