Center for
Natural Medicine, Inc.

Daniel J. Young ND, LAc

16844 Easy St. Eagle River, AK 99577
Phone: 907-694-5522 Fax: 907-694-5524

Patient Information

Name: _____ Date of Birth: _____
Mailing Address: _____
Home Phone: _____ Cell Phone: _____
Email: _____ SSN: _____
Occupation: _____
How did you hear about us? _____
Which number are we authorized to leave a message? _____
Primary Care Physician: _____
Emergency Contact, Relationship, and Phone Number:
_____
Circle your preferred method for appointment reminders: Email Cell Home

Insurance Information

Primary
Name of Insurance Company: _____
Name of Policy Holder: _____ SSN: _____ DOB: _____
ID Number: _____ Group Number: _____

Secondary
Name of Insurance Company: _____
Name of Policy Holder: _____ SSN: _____ DOB: _____
ID Number: _____ Group Number: _____

Cancelation Policy: There will be a fifty-dollar ($50.00) charge for appointments not cancelled within 24 hours of the scheduled appointment. THIS MUST BE PAID BEFORE SCHEDULING AN APPOINTMENT.

Client Policy Agreement

I understand that I am responsible for any charges NOT COVERED AND PAID by my insurance company or other third-party resources.

ASSIGNMENT OF INSURANCE/BENEFITS: We bill insurance as a courtesy. By signing below, I authorize THE CENTER FOR NATURAL MEDICINE to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. This authorization shall be valid only for the period necessary to process payment claim pertaining to the client but in any case, shall cease to be valid one (1) year from this date.

THIS FACILITY IS NOT ENROLLED IN FEDERAL OR STATE PROGRAMS, AND THEREFORE DOES NOT ACCEPT ASSIGNMENT OF BENEFITS FOR FINANCIAL PROGRAMS OF THIS NATURE.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

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Payment Policy:

Thank you for choosing The Center for Natural Medicine, Inc., for your healthcare needs. We are committed to providing you with quality and affordable health care.

1. **Insurance.** We are happy to bill your insurance as a courtesy. If you do not have insurance, payment in full is expected at each visit. If you are insured but do not have an up-to-date insurance card, payment in full for each visit is required until we obtain a copy of your current insurance card. Knowing your insurance benefits is your responsibility. Please contact your insurance company to see if your plan covers a Naturopathic provider and Licensed Acupuncture.
2. **Co-Payments and deductibles.** All co-payments, deductibles and/or co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. Non-Covered Services. Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by insurers. You must pay for these services in full at the time of visit.
4. **Proof of Insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.
5. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage Changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members will not be able to schedule any appointments until balance is paid in full. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed Appointments.** Our policy is to charge fifty dollars ($50.00) for missed appointments not cancelled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. Any balance accumulated because of a missed appointment fee will need to be paid before scheduling another appointment.

_____

Patient Signature

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Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Practice Policy

- It is your responsibility to notify this office of any changes of information, including name change, change of address, phone numbers and insurance.
- Your co-payment and/or co-insurance must be paid at each visit. You will be charged an additional co-pay amount if not paid on the same date of service
- We bill insurance as a courtesy. Any balance unpaid by your insurance company, or if your balance is outstanding for thirty (30) days, will be your responsibility. You will be responsible for any disputed claims. If/when the claim is paid, you will be reimbursed within thirty (30) days.
- Any disputes about coverage or benefits are your responsibility and are between you and your insurance carrier. If you have questions regarding coverage/payment, you must direct those inquiries to your insurance carrier.
- We recognize the usual holidays. During inclement weather, please contact the office to make sure we are open. If you have an emergency, call 911 or go to the nearest emergency room.
- All patients must give our office 24 hours' notice for cancellation. You will receive courtesy appointment reminder call/email the day prior to all appointments. However, PLEASE do not rely on the phone call or email to remember your scheduled appointment.
- There will be a fifty-dollar ($50.00) charge for appointments not cancelled within 24 hours of the scheduled appointment**. THIS MUST BE PAID BEFORE SCHEDULING AN APPOINTMENT.**
- If you have not been notified of any test results ordered by your provider within two (2) weeks, please call the office immediately at (907)694-5522.
- All appointments for lab work must be accompanied by or followed up with an office visit unless specifically stated otherwise by the provider. Results will not be provided otherwise.

_____
Patient Signature

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MEDICAL HEALTH QUESTIONNAIRE

PRIMARY HEALTH CONCERNS:
Please list in order of importance to you

1._____ 3. _____

2._____ 4. _____

In general, would you say your health is: Excellent Very Good Good Fair Poor

MEDICAL CARE

Please list other providers and or specialists involved in your care

Primary Care Provider (PCP): _____PCP Phone: _____

Referring Provider: _____Phone: _____

Other providers/specialists actively treating you (i.e., Physical Therapists, Chiropractor, Nurse Practitioner)

Provider/Specialists: _____Phone: _____

Provider/Specialists: _____Phone: _____

Have you ever consulted with a Naturopathic Doctor or Acupuncturist before (circle) Yes No

How did you hear about us:

Referral	Friend/Patient	Walk-in
Website	Social Media	Physician/Specialist

Relationship Status: Married Divorced Separated Single

Occupation: _____

What do you do for fun/Hobbies: _____

Who lives in your home?

Name	Relationship to you	Name	Relationship to you

NUTRITION AND LIFESTYLE

Describe your diet:

BREAKFAST	
LUNCH	
DINNER	
SNACK	
BEVERAGE	

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ALLERGIES

Please indicate allergy and reaction?

Type	Name/Reaction
Medication	
Food	
Seasonal	
Environmental	

□ No known drug allergies

MEDICAL CARE

Date of last physical exam:	Date of last lab work:
Date of last EKG:	Date of last tetanus shot:
Date of last TB test:	Date of last chest x-ray:
Date of last rectal exam:	

HOSPITALIZATIONS/SURGERIES – with Dates if known

COVID VACCINATION (circle):

Pfizer Moderna J&J Date dose #1_____Date dose #2 _____Date Booster _____

MEDICATION

Please list all medications and supplements you are taking including prescriptions, over-the-counter medications, vitamins, minerals, herbs and homeopathic remedies. Attach another page if necessary.

Name of medication/supplement (such as Synthroid, Vitamin D, etc.)	Strength (88mcg, etc)	Directions (such as 1 tablet twice a day, as needed, etc)
□ Check if none		

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MEDICAL HISTORY

Please check box to indicate if you or a family member has ever had the following conditions. Please indicate which relative has the condition (**MGM = maternal grandmother; MGF – maternal grandfather; PGM = paternal grandmother; PGF = paternal grandfathe**r).

Condition	Self	Mother	Father	Sibling	MGM	MGF	PGM	PGF
Allergies								
Anemia								
Anxiety								
Asthma								
Blood Transfusion								
Cancer								
Cataracts								
Congestive heart failure								
Clotting disorder								
COPD								
Depression								
Diabetes								
Ear Infections								
Eczema								
Emphysema								
Frequent Colds								
Frequent Headaches								
Gallstones								
GERD								
Glaucoma								
Gout								
Heart Attack								
Heart Murmur								
Hemorrhoids								
Herpes								
Hypertension								
Irritable Bowel Syndrome								
Kidney Disease								
Meningitis								
Migraines								
Mononucleosis								
Nerve/muscle disease								
Neurosis/psychosis								
Osteoporosis								
Parkinson's/Alzheimer's								
Psoriasis								
Seizures								
Sickle Cell Anemia								
STDs								
Stroke								
Substance Abuse								
Thyroid Disease								
Trauma, major								
Tuberculosis								
Ulcers								

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REVIEW OF SYSTEMS

(Please circle)

CONSTITUTIONAL

Weight gain	Yes or No	How many pounds? _____
Weight loss	Yes or No	How many pounds? _____
Fevers	Yes or No	
Chills	Yes or No	
Generalized weakness	Yes or No	
Fatigue	Yes or No	

TEMPERATURE

Normal	Yes or No	
Do you feel hot?	Yes or No	
Do you feel cold?	Yes or No	
Hot Flashes	Yes or No	Day/Night or Both

PERSPIRATION

Sweating	Yes or No	Normal/Minimal/Excessive
Night Sweats	Yes or No	

THIRST

Thirst	Increased/Decreased/Normal
Water preference	How many ounces per day? _____Room temp/Cold temp/Cold/Ice Cold Filtered Yes or No
Juice	Yes or No
Coffee	How many ounces per day? _____
Soda	Yes or No How many per day? _____
Energy Drinks	Yes or No How many per day? _____
Alcohol	Yes or No How many drinks per day/week/month? _____
Artificial Sweetener	NutraSweet, Splenda or other

APPETITE

Appetite	Increased/Decreased/Normal
Do you like to cook	Yes or No

How often do you eat fast food? _____

How often do you dine at restaurants? _____

DIGESTION

Blood Type	A+ A- B+ B- O+ O- AB+ AB-
Gas	Yes or No
Bloating	Yes or No
Heartburn	Yes or No
GERD	Yes or No
Nausea	Yes or No
Vomiting	Yes or No
Abdominal pain	Yes or No
Change in bowels	Yes or No

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REVIEW OF SYSTEMS CONT.

GENITOURINARY

Frequency with urination	Yes or No	
Urgency with urination	Yes or No	
Pain with urination	Yes or No	
Nighttime urination	Yes or No	How often? _____
Blood with urination	Yes or No	
Kidney Stones	Yes or No	
Discharge	Yes or No	

Women:

Age of first period?	_____
Date last menstrual period?	_____

MEN:

Date last prostate exam?	_____
Vasectomy	Yes or No

GASTROINTESTINAL

How many bowel movements per day? _____

Stools	Normal/Hard/Soft/Liquid	
Constipation	Yes or No	
Diarrhea	Yes or No	
Foul odor	Yes or No	
Blood with stools	Yes or No	
Hemorrhoids	Yes or No	
Colonoscopy	Yes or No	Most Recent? _____

ENERGY

Rate your energy level 0 to 10 (0=poor, 10 excellent)? _____
Morning or night person? _____

SLEEP

How many hours are you in bed? _____
What time do you go to bed? _____
What time do you get up? _____

Do you fall asleep easily?	Yes or No	
Do you have dreams/nightmares?	Yes or No	Do you remember them? Yes or No
Do you wake often?	Yes or No	
Snore	Yes or No	
Apnea	Yes or No	
CPAP	Yes or No	
What kind of mattress?	Memory foam/Inner spring/ Hybrid/ Gel Grid/ Other	
Do you wake up refreshed?	Yes or No	
Electronics in bedroom?	Yes or No	
Pets in your bed?	Yes or No	

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REVIEW OF SYSTEMS CONT.

HEENT:

HEAD

Traumatic Brain Injury	Yes or No
Headaches	Yes or No
Migraines	Yes or No

EYES

Regular vision checks	Yes or No
Glasses	Yes or No
Contacts	Yes or No
Cataracts	Yes or No
Glaucoma	Yes or No
Near-sighted	Yes or No
Far-sighted	Yes or No

EARS

Ringing in the ears	Yes or No
Hearing Loss	Yes or No
History of ear infections	Yes or No

NOSE

Deviated Septum	Yes or No
Post Nasal Drip	Yes or No
Sinus problems	Yes or No

MOUTH

Dental issues	Yes or No
Chew tobacco	Yes or No

THROAT

Tonsils	Yes or No
Difficulty swallowing	Yes or No

VERTIGO

Dizziness	Yes or No

CARDIOVASCULAR

High blood pressure	Yes or No
Palpitations	Yes or No
Chest pain	Yes or No
Resting shortness of breath	Yes or No
Ankle swelling	Yes or No

RESPIRATORY

Smoker	Yes or No	How many cigs/packs per day? _____
Asthma/wheezing	Yes or No	
Bronchitis	Yes or No	
Pneumonia	Yes or No	
Cough	Yes or No	
Did you get COVID?	Yes or No	How many times? _____

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REVIEW OF SYSTEMS CONT.

ABDOMEN

Hernia	Yes or No	
Gallbladder present	Yes or No	
Appendix present	Yes or No	
Abdominal surgeries/Trauma	Yes or No	What? _____
Cesarean section	Yes or No	

MENSTRUAL

Pregnancies	Yes or No	How many? _____	
Deliveries	Yes or No	How Many? _____	
Hysterectomy	Yes or No	When? _____	
Hot flashes	Yes or No		
Night sweats	Yes or No		
PAP	Yes or No	When? _____	Normal or Abnormal
Mammogram	Yes or No	When? _____	Normal or Abnormal
DEXA Scan	Yes or No	When? _____	

MUSCULOSKELETAL

Joint stiffness	Yes or No	
Joint pain	Yes or No	Pain level 0-10? _____
Joint swelling	Yes or No	
Leg cramps	Yes or No	
Muscle spasm	Yes or No	
Back pain	Yes or No	Pain level 0-10? _____
Neck pain	Yes or No	Pain level 0-10? _____
Hip pain	Yes or No	Right/Left Pain level 0-10? _____
Shoulder pain	Yes or No	Right/Left Pain level 0-10? _____
Elbow pain	Yes or No	Right/Left Pain level 0-10? _____
Ankle pain	Yes or No	Right/Left Pain level 0-10? _____
Knee pain	Yes or No	Right/Left Pain level 0-10? _____

NEUROLOGIC

Memory loss	Yes or No
Decreased concentration	Yes or No
Migraine headaches	Yes or No
Tremors	Yes or No
Seizures	Yes or No
Facial weakness	Yes or No

EXERCISE

What do you do for exercise? _____

How often? _____

INTEGUMENTARY

Dry skin	Yes or No	
Rash	Yes or No	Where? _____
Itchy skin	Yes or No	
Eczema	Yes or No	Where? _____
Psoriasis	Yes or No	Where? _____

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REVIEW OF SYSTEMS CONT.

INTEGUMENTARY CONT.

Suspicious lesions	Yes or No	Where? _____
Suspicious moles	Yes or No	Where? _____

ENDOCRINE

Thyroid condition	Yes or No	Hyper/Hypo
Hypoglycemia	Yes or No	
Diabetes	Yes or No	Type I/Type II
Cold intolerance	Yes or No	
Hot intolerance	Yes or No	
Excessive urination	Yes or No	

PSYCHIATRIC

Anger	Yes or No	
Depression	Yes or No	
Anxiety	Yes or No	
Short term memory loss	Yes or No	
Phobia	Yes or No	What? _____
Drug abuse	Yes or No	
Alcohol abuse	Yes or No	
Mood swings	Yes or No	
Stress	Yes or No	
Obsessive-compulsive	Yes or No	
ADHD	Yes or No	

HEMATOLOGY

Easy bruising	Yes or No
Swollen glands	Yes or No
Fatigue	Yes or No
History of blood transfusion	Yes or No

Extra Space if needed:

_____

_____

_____

_____

_____ _____

Provider's Signature **Date**