WINTERS NATUROPATHIC CLINIC
1606 6TH STREET
LA GRANDE, OR 97850

PATIENT NAME_____ DATE OF BIRTH_____

SOC. SECURITY # _____OTHER LAST NAMES USED_____

MAILING ADDRESS_____ CITY_____ZIP_____

HOME PHONE #_____WORK #_____ EMPLOYER_____

OCCUPATION_____ MARITAL STATUS: MARRIED___ SINGLE___OTHER___

E MAIL ADDRESS _____

IN CASE OF EMERGENCY, WHOM SHALL WE CONTACT? _____

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WHAT OTHER DOCTORS HAVE YOU SEEN? _____

IS THIS YOUR FIRST VISIT TO A NATUROPATH? _____

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DO YOU HAVE INSURANCE? _____

IF SO PLEASE MAKE SURE TO GIVE A COPY OF YOUR INSURANCE CARD TO OUR OFFICE.

I understand that I am responsible for payment of all charges incurred on this account. In the event that my insurance provides coverage for naturopathic care, I herby authorize Dr. Winters to release medical or other information necessary for insurance purposes. I also assign payment of benefits to John Winters, N.D.

SIGNATURE_____DATE_____

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If someone other than the patient is responsible for payment please complete the following

PERSON RESPONSIBLE FOR BILL_____

RELATIONSHIP TO PATIENT_____ SSN_____

MAILING ADDRESS_____CITY_____ZIP_____

HOME PHONE#_____WORK PHONE#_____

WINTERS NATUROPATHIC CLINIC FINANCIAL POLICY

In the interest of excellent health care, it is desirable to establish a credit policy to avoid misunderstandings. My primary responsibility is to help my patients attain and maintain excellent health; I wish to spend my time and energy toward that end.

All accounts are due at the time of your visit unless prior arrangements are made with the receptionist. New patients are expected to pay full payment for the first visit at the time of the first visit. Monthly statements will be due upon receipt. Any balance outstanding more than 90 days will be sent to collections unless other arrangements have been made.

MY OFFICE FEES:	INTIAL CONSULTAION	125.00
	STANDARD OFFICE VISIT (30 MINUTES)	75.00
	EXTENDED OFFICE VISIT	VARIES
	PHARMACY FEES	VARY
	LABORATORY FEES	VARY
	FOOD INTOLERANCE TEST	90.00
	PHONE CONSULTATION	VARY

Please provide us with at least 24 **HOURS NOTICE** for cancellation or rescheduling of your appointments: my time must be used as efficiently as possible to minimize my expenses and keep my fees within reasonable limits.

As a courtesy, we gladly bill **INSURANCE** when provided with current information and necessary forms. Deductibles, co-pays and non-covered services are to be paid for at the time of service. **Pharmacy items are rarely covered by insurance carriers and must be paid for upon receipt.**
Insurance reimbursement is a contract between you, your employer and your insurance carrier- we cannot be responsible for negotiating disputed claims or for collecting insurance claims over 60days.

MEDICARE DOES NOT PROVIDE ANY NATUROPATHIC COVERAGE AND MEDICAID COVERAGE IS QUITE LIMITED.

I have read this financial policy and understand that, regardless of any insurance coverage, I am responsible for payment of my account. I also understand that delinquent accounts will be assigned to a reporting collection service.

Signature_____ Date_____

Patient History

Do you currently have, or have had problems with...

- ☐ Headache more than once a week
- ☐ Difficulty with swallowing
- ☐ Swollen glands, lumps in neck
- ☐ Chronic cough
- ☐ Ankle swelling
- ☐ Nausea, vomiting (chronic)
- ☐ Abdominal pain or heartburn
- ☐ Hemorrhoids
- ☐ Frequent urinary tract infections
- ☐ Urination more than once after bedtime
- ☐ Arthritis, rheumatism
- ☐ Sore, cramping or weak muscles
- ☐ Heat or cold intolerance
- ☐ Loss of Consciousness or convulsions
- ☐ Weight change more than 5# in the last year
- ☐ Easy bruising or bleeding
- ☐ More thirsty than usual
- ☐ History of high blood pressure
- ☐ History of low blood pressure
- ☐ Low blood sugar
- ☐ Difficulty hearing or ear drainage
- ☐ Sores in mouth
- ☐ Thyroid trouble
- ☐ Chest pain or tightness
- ☐ Change in appetite
- ☐ Yellow jaundice
- ☐ Bloody or black stool
- ☐ Blood in urine
- ☐ Venereal disease history or HIV/AIDS
- ☐ Prostate trouble
- ☐ Red, swollen or painful joints
- ☐ Chronic back pain
- ☐ Sweating or flushing
- ☐ Difficulty with balance
- ☐ Fevers, chills, night sweats
- ☐ Swollen glands anywhere
- ☐ Sexual difficulties
- ☐ Lumps in breast
- ☐ Blood or plasma transfusions
- ☐ High blood sugar

Date of Last PAP or Prostate exam _____ Results normal? _____

List serious medical illness or hospitalizations as well as approximate dates of any serious illnesses, injuries, surgeries, auto accident, etc.

_____

_____

_____

_____

Number of Pregnancies_____Number of Births_____

Allergies to Drugs_____

Allergies to Food_____

Unusual or Prolonged Childhood Illnesses_____

Unusual or Prolonged Adult Illnesses_____

Immunizations_____

Current Medications, Vitamins, Supplements, & Non-Prescriptions

_____

_____

_____

Do you smoke or chew tobacco? _____ Packs per day_____ for how many years _____

Drink coffee, tea or soft drinks? _____ Cups per day_____

Do you drink alcohol? _____ Amount/day_____/week_____/month_____

GENETIC HISTORY

Check those conditions that have been problematic in your family.

Condition	Mother	Father	Sisters	Brothers	Others		
Overall Health	good/ poor	good/ poor	good/ poor	good/ poor			
Allergies/ Asthma							
Diabetes							
Cancer/ Tumor							
Heart Trouble							
High Blood Pressure							
Kidney Disease							
Arthritis/ Rheumatis							
Thyroid Disease							