

Welcome to Cherubino Health Center

Leading the Way in Alternative Health Care Since 1982

INSTRUCTIONS:

- 1.) Fill in the sections that apply to you
- 2.) If you need assistance or have any questions please feel free to ask the receptionist

(A) -- CONFIDENTIAL PATIENT INFORMATION --

Today's Date: / /20

Patient's Name: _____ SS#: _____

Address: (Street, city, state, zip) _____

Home Phone: () _____ Work Phone: () _____

Other Phone: () _____ e-mail address: _____ @ _____

Birthdate: _____ / _____ / _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Employer: _____

Name of person to contact in emergency: _____ Phone: () _____

Will future visits be covered by: Insurance Cash Other: _____

Insurance Company Name: _____

Address:(Street, city, state, zip) _____

_____ Phone: () _____

Group #: _____ ID #: _____

Name of Insured: _____ SS#: _____

Insured's employer: _____

If you were referred to our center, whom may we thank? _____

If you were not referred, how did you hear about us? Radio Internet Newspaper

Television Other: _____

Reason for this visit: _____

Are you interested in? (mark all that apply) correction of specific condition(s) maintenance care

improvement of overall health preventative care a quick fix

care of chronic condition pain control specific technique(s): _____

Other: _____

(B) -- PERSONAL INJURY INFORMATION --

To Be Filled In By Motor Vehicle & Work Injured Patients

Date of Injury: _____ Place: _____

Type: Auto Accident Work-related Other: _____

Are You Disabled? Yes No Date Disability Began: _____

Has a Lawyer Been Retained? Yes No Name: _____

Address:(Street, city, state, zip) _____

_____ Phone: () _____

MORE →

(C)**-- HEALTH HISTORY --**

Please fill in **date and type** for those that apply:

Operations: _____

Currently Diagnosed Conditions: _____

Current Medications: _____

HABITS: *(Amount per day)*

Sleep: _____ Exercise: _____ Work: _____ Relaxation: _____

Coffee: _____ Tea: _____ Tobacco: _____ Alcohol: _____

Do you feel that your health is: poor fair good excellent

Do you consider yourself to be under *stress*? yes no

List any supplements you are currently taking: (*vitamins, minerals, herbs, homeopathic, etc.*)

ALTERNATIVE TREATMENT HISTORY:

Please mark any of the following alternative therapies that you have utilized:

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Osteopathy | <input type="checkbox"/> Holistic Medical | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Naturopathy | <input type="checkbox"/> Herbology | <input type="checkbox"/> Therapeutic Massage |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> BioEnergetics | <input type="checkbox"/> Chi Quong | <input type="checkbox"/> CranioSacral Therapy |

Other: _____

(D)**-- INFORMED CONSENT --****All Patients must sign this section before they can be examined or treated.**

1. I understand and agree that health insurance and accident insurance policies are an arrangement between my insurance carrier and myself. I understand that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I also understand that all services rendered to me are charged directly to me and that I am responsible for payment.

2. Permission is given by me to the doctors/practitioners of this office, and whomever he/she designates, to treat me. I acknowledge that I have read the *Notice of Privacy Practices, Informed Consent* and *Cherubino Health Center Policies and Procedures* documents and fully understood them and have had all my questions answered to my satisfaction, and that additional copies of these documents are available to me upon request.

MY SIGNATURE IS AN ACKNOWLEDGMENT THAT I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

Patient's Signature: _____ **Today's date:** _____

If the patient is a minor, permission is given by me to the doctor/practitioner of this office and whomever he/she designates to treat the patient. I am his/her legal guardian.

Guardian Signature: _____ **Today's date:** _____