PATIENT INFORMATION

(PLEASE FILL IN COMPLETELY, ALL INFORMATION IS REQUIRED)

LAST NAME: _____ FIRST: _____MI: _____

STREET ADDRESS: _____APT/FL: _____

CITY: _____ STATE: _____ ZIP/POSTAL: _____ COUNTRY: _____

HOME #: _____ MOBILE #: _____ WORK#: _____ PREFERRED: _____

DOB (M/D/Y): _____/_____/_____ SSN: _____ SEX: _____ RACE: _____

EMAIL: _____ MARITAL STATUS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

REFERRED BY: _____ EMPLOYER: _____ OCCUPATION: _____

HOW DID YOU HEAR ABOUT US: _____ ALLERGIES (INCLUDING MEDS): _____

GUARANTOR'S INFORMATION

GUARANTOR LAST NAME: _____ FIRST: _____ MI: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DOB (M/D/Y): _____/_____/_____ PHONE: _____ (HOME / MOBILE / WORK)

GENDER: _____ RELATIONSHIP TO PATIENT: _____

PHARMACY (required): _____

NAME STREET TOWN STATE

PHARMACY PHONE: _____ PHARMACY FAX: _____

HEALTH INFORMATION

PRIMARY CARE CLINICIAN: _____ CITY/ STATE: _____ PHONE: _____

SPECIALIST: _____ SPECIALTY: _____CITY/ STATE: _____

SPECIALIST: _____ SPECIALTY: _____CITY/ STATE: _____

SPECIALIST: _____ SPECIALTY: _____CITY/ STATE: _____

CURRENT MEDICATIONS: NONE

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

CURRENT SUPPLEMENTS: NONE

_____ DOSAGE: _____ FREQUENCY: _____

_____ DOSAGE: _____ FREQUENCY: _____

_____ DOSAGE: _____ FREQUENCY: _____

ALLERGIES:

MEDICATION ALLERGIES: NONE _____

OTHER ALLERGIES: _____

HOSPITALIZATIONS/ SURGICAL HISTORY EVENT YEAR STATE

_____

_____

_____

_____

FAMILY HISTORY ARE YOU ADOPTED? (circle) YES / NO

Please list any health conditions, including specific names of neurologic, autoimmune, cardiovascular, or cancerous processes. If deceased, please indicate AGE and CAUSE (if known). If adopted, please include both adoptive and biological family information by attaching a separate sheet, if known.

Mother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Father: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Siblings (identify age/ sex): _____

Siblings (identify age/ sex): _____

Children (identify age/ sex): _____

Children (identify age/ sex): _____

SOCIAL HISTORY OCCUPATION: _____

DRINKS PER WEEK: _____ RETIRED ☐ PRESENTLY DISABLED ☐PHYSICALLY DISABLED ☐

CURRENT SMOKER ☐ PRIOR SMOKER (QUIT) ☐ if so, # packs per day, year of quitting _____

HAVE YOU TRAVELED OUTSIDE THE USA? NO / YES (please list countries & years): _____

_____

HAVE YOU HAD THE FOLLOWING IMMUNIZATIONS? (If Yes, please list YEAR of most recent)

PRESENT GOALS / REASON FOR VISIT

Please write your achievable health goals/ most problematic symptoms in order of priority (for example, do not write "want to feel healthy"- too unclear)

1. _____
2. _____
3. _____

BRIEF NARRATIVE

Briefly describe the reason(s) for your visit in this space, to provide context to your practitioner (optional):

_____
_____
_____
_____
_____
_____

GENERAL HEALTH QUESTIONNAIRE

Have you had prolonged or regular use of NSAIDs? (e.g. Advil, Aleve, Motrin, Aspirin, etc.) YES / NO
Have you had prolonged or regular use of antibiotics (e.g. Amoxicillin, Doxycycline, Z-pack, etc.) YES / NO
Have you had prolonged or regular use of steroids? (Prednisone, Hydrocortisone, Medrol, Kenalog, etc.) YES / NO

TESTS & PROCEDURES

Please indicate which of the following you have had, including year(s), and outcome (if routine/preventative, please indicate so)

MRI head ☐ yr ____ outcome _____ MRI (area _____) ☐ yr ____;_____

Colonoscopy ☐ yr ____ outcome _____ Endoscopy ☐ yr ____ outcome _____

Lumbar puncture ☐ yr ____ outcome _____ Other: _____

PAST & PRESENT MEDICAL HISTORY **(***applies to diagnosed findings only)*

	N/A	**Year (first presented)**	**Resolved?**	**Ongoing Issue(s)?**	**If symptomatically managed, How?**
Bell's Palsy	☐		☐		
One swollen knee	☐		☐		
Anxiety Disorder	☐		☐		
Iron-deficient anemia	☐		☐		
Irritable Bowel Syndrome	☐		☐		
Motor tic disease	☐		☐		
Recurrent strep throat	☐		☐		
Obsessive-Compulsive Disorder	☐		☐		
Acid reflux	☐		☐		
Stomach Ulcer(s)	☐		☐		
Gallbladder Disease	☐		☐		
Liver Disease	☐		☐		
Chron's Disease	☐		☐		
Ulcerative Colitis	☐		☐		
Celiac Disease	☐		☐		
Tuberculosis	☐		☐		
Asthma	☐		☐		
Sleep Apnea	☐		☐		
Chronic Sinusitis	☐		☐		
Pneumonia	☐		☐		
Chronic Bronchitis	☐		☐		
High blood pressure	☐		☐		

Low blood pressure __☐_____☐_____

Blood clots__☐_____☐_____
Hemophilia __☐_____☐_____

Heart attack__☐_____☐_____
Coronary artery disease __☐_____☐_____
High cholesterol__☐_____☐_____
High triglycerides __☐_____☐_____

Elevated blood sugear (pre-diabetic)__☐_____☐_____
Diabetes (early onset) __☐_____☐_____
Diabetes (adult onset)_☐_____☐_____

Thyroid nodules _☐_____☐_____
Low thyroid (Hypo) _☐_____☐_____
Hashimoto's thyroiditis _☐_____☐_____
High thyroid (Hyper)__☐_____☐_____
Graves disease __☐_____☐_____
Goiter (thyroid problems)_☐_____☐_____

Stroke_☐_____☐_____
ADD/ADHD __☐_____☐_____
(diagnosed) Seizures_☐_____☐_____
Brain injury/concussion __☐_____☐_____
Depression_☐_____☐_____

Rheumatoid arthritis_☐_____☐_____
Gout (arthritis)_☐_____☐_____
Arthritis- other (specify)_☐_____☐_____

Mononucleosis (mono) __☐_____☐_____
Herpes_☐_____☐_____
HIV_☐_____☐_____
Hepatitis_☐_____☐_____
Shingles_☐_____☐_____
Multiple Sclerosis__☐_____☐_____
Lupus (SLE)_☐_____☐_____

Chronic Fatigue Syndrome_☐_____☐_____
Fibromyalgia_☐_____☐_____

Breast cancer_☐_____☐_____
Thyroid cancer _☐_____☐_____
Cancer (specify) ☐_____☐_____
[FEMALE] How many times have you been pregnant: ____ How many times have you given birth: _____ Have you had miscarriages (#)? _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

WAVE INTEGRATIVE MEDICAL CENTER
11 WOODLAND RD, STE 202 MADISON CT
P: 844.468.5963 F: 860.263.0576

THIS DOCUMENT IS TO BE SIGNED BY THE PERSON LEGALLY RESPONSIBLE FOR THE PATIENT'S MEDICAL DECISIONS RELATIVE TO THE TREATMENT SITUATION.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I, _____, hereby acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of these uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____

Patient Name _____

Relationship to Patient _____

Date _____

"I allow Wave Integrative Medical Center to obtain prescription history from an external source."

Signature _____

Patient Name _____

Relationship to Patient _____

Date _____

AUTHORIZATION & RELEASE

WAVE INTEGRATIVE MEDICAL CENTER
11 WOODLAND RD, STE 202 MADISON CT
P: 844.468.5963 F: 860.263.0576

RECORDS RELEASE FOR HEALTH INSURANCE CLAIM FORM

I authorize the release of any medical or other information necessary to process the health insurance claim forms ("superbills") provided for each visit.

AUTHORIZATION FOR TREATMENT

I voluntarily consent to the administration and costs of medical and/or acupuncture procedures for myself or my dependent. I am aware that Wave Integrative Medical Center treats within **Goal-Directed Standards of Care** for which guidelines will be disclosed during my visit. I am aware that Wave Integrative Medical Center does not provide primary care; requires that I have primary care, and does not provide emergency after-hours care, and that for this I will need to seek primary care evaluation or emergency medicine / walk-in services.

GUARANTEE OF PAYMENT

I understand that I am financially responsible for and agree to pay all charges that are not paid or billed to a third party payer. I understand that it is Wave Integrative Medical Center's policy to collect charges up front when checking in for appointments. I also understand that additional services or missed & rescheduled appointments may result in additional charges as outlined in the patient handbook. Further, I understand that I may bill my insurance payer directly as Wave Integrative Medical Center is not contracted to do so.

Signature _____

Patient Name _____

Relationship to Patient _____

Date _____

CONSENT FOR NOTIFICATION OF INFORMATION

I understand that I must request to copy clinicians or other specialists on my testing for results to be routinely transferred.

I understand that by bringing another person into the appointment room with me, I consent to the sharing of health-related information to them.

I give permission to *Wave Integrative Medical Center* to leave appointment or health-related information in my voicemail box.

Signature _____

Patient Name _____

Relationship to Patient _____

Date _____