Dr Jennifer Potter ND
Patient Registration Form

Date: _____

New Patient Information

Name: _____ Sex: _____ DOB: _____/_____/_____ Age: _____

Address:_____City: _____ ST: _____ Zip:_____

Home Phone:_____Cell Phone: _____ Work Phone: _____

Email Address: _____ Would you like to receive our email newsletter? Y N

Additional Patient Information

Employer: _____ Occupation:_____

Marital Status (circle): Single Married Separated Divorced With Partner Engaged Widow(er)

Number of children: _____ Name of Spouse/Partner: _____

Emergency Contact: _____ Relationship to you: _____

Emergency Contact phone: _____

Primary Care Physician: _____ Physician's Phone: _____
Address/Hospital:_____City: _____ ST: _____

How did you hear about Dr. Potter? Google Website Yelp Referred by _____ Other _____

Acknowledgement of Forms: Notice of Privacy Practices, Informed Consent, and Email Consent

Dr Jennifer Potter ND reserves the right to modify the forms.

Initials: _____ I have read a copy of the Notice of Privacy Practices and Informed Consent for Dr Jennifer Potter ND available at naturopathhealing.com

- I acknowledge that no guarantees have been given to me by Dr. Potter regarding cure or improvement of my condition
- I understand that there are risks to procedures and will go to URGENT CARE if needed.
- I understand that Dr. Potter has polices about labs and lab reviews.
- I understand that Dr. Potter treatment recommendations are for the patient only. Sharing recommendations can be dangerous to other persons (i.e. sharing with a pregnant woman)
- I understand that Dr. Potter can provide supplements and vitamins for convenience and that patients are not obligated to purchase from Dr. Potter. However, I am responsible for the therapeutic quality of the product.
- I understand that purchasing from Dr. Potter supports the naturopathic medical practice.

Initials: _____ I have read a copy of the Email Consent Form available at naturopathhealing.com

- I understand that email is NEVER for emergency/urgent matters
- I understand that email is like a postcard and is not confidential. Any member of Dr. Potter's medical or reception team can have access to the emails.
- I understand that email is ONLY for quick questions about product refill, scheduling, and emailing invoices and forms.

Initials: _____ I would like to receive interesting health information, and/or newsletters from Dr. Potter.

FINANCIAL RESPONSIBILITY AND POLICY STATEMENT
Effective May 2014. Updated October 2016.

Thank you for choosing the naturopathic medical practice of Dr Jennifer Potter, ND for your healthcare needs. We are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

PAYMENT FOR SERVICES
Dr Jennifer Potter ND is a fee for service medical practice. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

In the state of California, no insurance plans directly cover Naturopathic Doctors (ND). This is a complex issue and the California Naturopathic Doctors Association is exploring how this problem can be solved for Californians. Unfortunately, it is not California law to mandate coverage for patients to see NDs at this time. For these reasons, Naturopathic Doctors bill as fee for service practices.

- New Patient visits are $395 for the 90 minute visit.
- Follow-up appointments including lab reviews are billed at $275 per appointment, approximately 30-45 minutes.

For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover, and American Express. Returned checks are subject to a $50 return fee and no further personal checks will be accepted.

CANCELLATION POLICY
If you are not able to keep your scheduled appointment, please notify us within 48 hours of the appointment. There is no charge if an appointment is cancelled within 48 hours during Monday-Saturday business hours of 9am-6pm. A cancellation with less than 48 hours notice does not allow enough time for other interested patients to be scheduled, and is a great inconvenience for the practice. Late cancellations will be billed at full visit cost for new patients $395 and $275 for all established patients.

I agree to the above defined financial policies. In case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I the undersigned, have read, understand and accept the information and conditions specified in this document.

_____ _____
Patient or Parent/Guardian Signature Date

NATUROPATHIC PATIENT INTAKE FORM

Name:_____**DOB:**_____

List in order of importance your health concerns:

1)_____

2)_____

3)_____

4)_____

Last time you had blood work done

_____

Please indicate the following: Disease **(D), I**mmunized **(I),** or **N**either **(N):**

Standard childhood immunizations **:** D I N *(Measles, Mumps, Rubella (MMR), Tetanus, Diphtheria, Pertussis (DTP), Polio)*

Chicken Pox	D I N	Tetanus	D I N	Whopping Cough	D I N
Hepatitis B	D I N	HPV	D I N	Flu	D I N

Did/do you have any of the following health concerns: Yes (**Y**) No (**N**) Past (**P**)

Scarlet Fever	Y N P	Diabetes	Y N P	Kidney Disease	Y N P
Hypertension	Y N P	Seizures	Y N P	Tuberculosis	Y N P

List all known drug allergies and reaction you get when you take medicine:

_____

_____

List all Prescription Medicines & Nutrient Supplements/Herbs that you are taking and include dosage

Medications	Dosage	How long have you been taking it?	Prescribed by Dr's or self?	Side effects

Do you currently see a chiropractic doctor? _____

Do you have a regular dentist? _____

Family History

	Self	Mother	Father	Siblings	Aunt/Uncle	Grandparent	Children
Allergies/ Asthma							
Auto-Immune Disease							
Cancer/Type							
Diabetes							
High Blood Pressure							
Mental Illness							
Obesity							
Osteoporosis							
Stroke/Heart attack							
Thyroid Disease							

Energy

What would you rate your energy on a scale from 1-10? (10 being the best)_____ **Do you have fatigue?** Yes/No

If you have fatigue, when in the morning, afternoon, evenings is it the worst?_____

If you have fatigue, can you do what you need to do during the day?_____

Exercise

How often do you exercise?_____**What type of exercise?** _____

For how long? _____

Hobbies:_____

Sleep

How long per night?_____**If you wake up frequently, what is the reason?**_____

Nightmares: Y N P **Wake refreshed:** Y N P **Must nap during day:** Y N P

Sleep walk: Y N P **Grind teeth:** Y N P **Snore:** Y N P

Social and Work Life

Enjoy job: Y N P **Hours worked per week**:_____ **Occupation**: _____

Highest level of education:_____ **How do you relieve stress?** _____

Spiritually fulfilled: Y N P n/a **Quality of significant relationship:**_____

History of sexual, mental/emotional, physical abuse: Y N P **If so, at what age and by whom:** _____

Do you consume alcohol: Y N P Frequency _____ **Recreational drugs:** Y N P Frequency _____

Cigarettes or other tobacco product: Y N P Frequency _____

Toxin Exposure

Have you had any job where you were exposed to solvents, heavy metals, fumes or other toxic material?_____

_____

Any past tick bites? _____

Allergies

List all known Allergies (food, environment): _____

_____

_____

Surgeries/Hospitalizations

Approximate year(s) and reason:_____

_____

What is your greatest health concern today?_____

_____

How does it limit you the most?_____

_____

Which statement best describes your attitude towards your health? (Check one)

- ❑ I will do whatever it takes to obtain optimal health
- ❑ I am willing to change my lifestyle somewhat to feel better
- ❑ I may consider change if needed to feel better
- ❑ Just give me pills, doc

Please indicate **Y** (yes, presently) **N** (no, never) **P** (past concern)

SKIN			
Rash	Y N P	Color change	Y N P
Hives	Y N P	Psoriasis/eczema	Y N P
Extreme dryness	Y N P	Skin cancer	Y N P
HEAD			
Headache/Migraine	Y N P	Head injury	Y N P
Oil/Dry hair	Y N P	Hair loss	Y N P
NOSE			
Frequent colds	Y N P	Post Nasal Drip	Y N P
Chronic congestion	Y N P	Seasonal Allergies	Y N P
EYES			
Dry/Watery	Y N P	Glaucoma	Y N P
Double vision	Y N P	Cataracts	Y N P
EARS			
Ear infections	Y N P	Ringing or buzzing	Y N P
Vertigo/dizziness	Y N P	Loss of hearing	Y N P
MOUTH/THROAT			
Canker sores	Y N P	Cold sores	Y N P
Chronic sore throat	Y N P	Gum disease	Y N P
Loss of taste	Y N P	Hoarseness	Y N P
NECK			
Unusual stiffness	Y N P	Swollen glands	Y N P
Lack of motion	Y N P	Disc complaints	Y N P
RESPIRATORY			
Chronic cough	Y N P	Chronic bronchitis	Y N P
Shortness of breath	Y N P	Pneumonia	Y N P
Wheezing	Y N P	Asthma	Y N P
TB	Y N P	Painful breathing	Y N P
CARDIOVASCULAR			
High blood pressure	Y N P	Rheumatic fever	Y N P
Low blood pressure	Y N P	Murmurs	Y N P
Arrhythmias	Y N P	Palpitations	Y N P
Edema/swelling	Y N P	Chest pain	Y N P
ENDOCRINE/IMMUNE SYSTEM			
Hypothyroidism	Y N P	Anemia/Easy bruising	Y N P
Hyperthyroidism	Y N P	Auto immune	Y N P
NERVOUS SYSTEM			
Paralysis	Y N P	Sciatica/Disc issues	Y N P
Seizures	Y N P	Fainting	Y N P

GASTROINTESTINAL			
Heartburn/Indigestion	Y N P	Bowel Movements	_____ per day
Bloating	Y N P	Recent BM change	Y N P
Nausea/Vomiting	Y N P	Diarrhea	Y N P
Ulcer	Y N P	Constipation	Y N P
Pancreatitis	Y N P	Gallbladder disease	Y N P
GI surgery	Y N P	Liver disease	Y N P

MUSCULOSKELETAL			
Weakness	Y N P	Arthritis	Y N P
Stiffness	Y N P	Leg cramps	Y N P
Tremors	Y N P	Pain	Y N P

MENTAL/EMOTIONAL			
Depression	Y N P	Anger/irritability	Y N P
Suicidal	Y N P	Panic attacks	Y N P
Anxiety	Y N P	Memory problems	Y N P

URINARY TRACT			
Incontinence	Y N P	Pain w/ urination	Y N P
Frequent infections	Y N P	Kidney stones	Y N P
Urgency	Y N P	Discharge/blood	Y N P

MALE HEALTH			
Testicular pain	Y N P	Sexually active	Y N P
Discharge	Y N P	STD	Y N P
Impotency	Y N P	Prostate complaints	Y N P

FEMALE HEALTH			
Age period began	_____	How often period occurs	_____
Last menstrual period	_____	Length of period	_____
Avg # of pads/tampons used	_____	Heavy bleeding	Y N P
PMS	Y N P	Pain/cramping	Y N P
Times pregnant	_____	How many births	_____
Miscarriages	_____	Abortions	_____
Any abnormal paps	Y N P	Hormonal birth control*	Y N P
STD	Y N P	Breast self exams	Y N
Vaginitis/Yeast Infections	Y N P		
	Menopause		
Menopausal since	_____	Use of hormones*	Y N P
Dry vagina	Y N P	Healthy libido	Y N P
Pain with intercourse	Y N P	Hot flashes/Nightsweats	Y N P
Dexa bone scan	Y N P	Mammography	Y N P

*Please list any birth control or hormone treatments used and ages used: _____
_____