



829 NE HWY 99W  
McMinnville, OR 97128  
Phone: (503) 883-0333  
Fax: (503) 503-857-0622

Thank you for making an appointment with A Family Healing Center.

We are Committed to providing excellent care, in a compassionate and caring environment. Our mission is to achieve optimal health for the individuals and the community we serve. Our success is measured by your satisfaction.

For your convenience, and to minimize waiting time in our office we have attached forms for you to complete prior to your visit. Please take a few minutes to fill these out and email or fax back to us before your first appointment. Our fax number is 503-857-0622. If you prefer to use email you can return the paperwork to [info@afamilyhealingcenter.com](mailto:info@afamilyhealingcenter.com).

Please arrive 20 minutes early if you will be bringing your paperwork with you to your first appointment to allow us time to process your paperwork.

Cancellation policy: We have a 24 hour cancellation policy. Please call our office within 24 hours of your scheduled appointment to avoid a cancellation fee. If you no show or cancel with less than 24 hours of notice 3 times we will discontinue your care.

Prescription refill policy: Our office processes prescription refill requests within 72 hours from receiving them. Please contact your pharmacy a minimum of 1 week before you are completely out of your medication and have your pharmacy fax us a request.

As a reminder, please arrive with the following information for your appointment:

Completed Paperwork  
Insurance Card  
Photo ID  
Copay or Coinsurance  
List fo medication or supplements you are already on

During your visit, please feel free to ask any questions or share any concerns you may have. Your healthcare is a partnership, and we are counting on you to take an active role. This includes freely discussing symptoms as well as leading a healthy lifestyle. We look forward to meeting you and being a partner in your healthcare.

If you have any questions, do not hesitate to contact our office.

Sincerely,

Dr. Jason Black  
Dr. Jessie Black  
Dr. Kalli Keddie

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## Individual Patient Registration

MUST BE COMPLETED BY PARENT / GUARDIAN FOR MINOR (UNDER 18) PATIENTS

### PATIENT INTAKE INFORMATION:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
CELL Phone: \_\_\_\_\_ HOME Phone: \_\_\_\_\_  
Primary Care Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Social security Number: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Is your current condition the result of an accident (car, work, fall etc.) \_\_\_\_ Y \_\_\_\_ N?

### RESPONSIBLE PARTY INFORMATION / GUARDIAN (If different from above):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

### INSURANCE INFORMATION:

If you would like your insurance billed for you, the following information must be complete.

Primary Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Does your coverage include Naturopathic Care? \_\_\_\_ Y \_\_\_\_ N

### Emergency Information: Person(s) to contact in case of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_



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**DEMOGRAPHICS:**

**Race:**

- Decline
- American Indian or Alaska Native
- Asian
- African American
- White
- Other: \_\_\_\_\_

**Ethnicity:**

- Decline
- Hispanic
- Latino
- Not Hispanic/Latino
- Other: \_\_\_\_\_

**Preferred Language**

- Decline
- English
- Spanish
- Other: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been given A Family Healing Center, Notice of Privacy Practices\*. I understand that if I have questions or complaints, I may contact the Facility Privacy Official. \* Available at check-in, online at www.afamilyhealingcenter.com or through the patient portal.

**DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO PATIENTS FAMILY OR OTHERS**

Under the Health Insurance Portability and Accountability Act of 1996, as amended, patients have the right to agree, restrict or object to providing PHI to family members or other person identified as involved in the patient's care or payment for the patient's healthcare. To comply with the regulations, as outlined in our facility policies, documentation of the patient's wishes must be present in the medical record.

**I am granting permission for A Family Healing Center to release PHI concerning myself to:**

- Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_
- Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_
- Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

**I give permission for the clinic medical staff to (Please Initial)**

Leave a detailed message concerning billing, lab and/or test results on my voicemail, email, by text message or answering machine

Release my written prescriptions and/or samples to the following individual(s) (Must be over 18 years of age):

- Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_
- Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

**MEDICATION HISTORY NOTICE ACKNOWLEDGEMENT**

I understand that A Family Healing Center (AFHC) may need access to my medication history and may work in conjunction with my pharmacy and / or insurance carrier to provide accurate medical treatment. AFHC has permission to contact them as needed for this purpose.

**Patient Signature if 18 years or older:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Pharmacy of choice:** \_\_\_\_\_



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**PATIENT PORTAL, EMAIL & TEXT MESSAGING COMMUNICATION NOTICE ACKNOWLEDGEMENT**

Our clinic requires patients to provide a valid email address for access to our Patient Portal, to assist the Clinic to in complying with Federal “Meaningful Use” Requirements, and for communication that may contain “Protected Health Information”. Patient acknowledges that all Patient Appointments and Care Documents will be made available on their Patient Portal for all Encounters after September 15, 2016, and agrees to access their Portal for this information.

The Practice will use reasonable means to protect the security and confidentiality of e-mail and text messaging information sent and received. Patient agrees that Practice may utilize email correspondence for all healthcare related billing matters, including sending emails that contain PHI (Protected Health Information) and billing information which may contain Clinic billing statements, Explanation of Benefits and Explanation of Payments received from your Insurance, and any other documents related to your healthcare and billing documentation. The Practice cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is the subject of the federal Health Insurance Portability and Accountability Act of 1996) that is not caused by the Practice’s intentional misconduct.

**Patient Email Address To Receive Clinic Correspondence:** \_\_\_\_\_

I acknowledge that I have read and fully understand the information the Practice has provided me regarding the risks of using e-mail. **Patient Initials:** \_\_\_\_\_ **Date Initialed:** \_\_\_\_\_

My signature below indicates that I have been given the chance to read and review the following and understand and agree to their terms:

- Financial Policy, Consent for Treatment and Release of Medical information
- Patient Portal, Email & Text Messaging Communication Notice Acknowledgment
- Patient Acknowledgment Agreement
- HIPAA Notice of Privacy Practices Patient Acknowledgment Form

I agree that the above information is true and I authorize A Family Healing Center to use this information to obtain financial reimbursement. Additionally, I authorize A Family Healing Center to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to A Family Healing Center. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. This authorization is to remain in full force unless I revoke the same in writing.

**Patient/Responsible Party Signature:** \_\_\_\_\_

**Patient's Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_



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## HIPAA NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT FORM

I understand that the patient's health information is private and confidential. I understand that A Family Healing Center works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. A Family Healing Center displays a copy of their "NOTICE OF PRIVACY PRACTICES" at our front desk, on your patient portal, and on our web-site, [www.afamilyhealingcenter.com](http://www.afamilyhealingcenter.com)

I understand that A Family Healing Center may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that there may be situations where A Family Healing Center is required by federal, state, or local law to release this information without my permission. One example would be in response to a warrant, summons, court order, subpoena or similar legal process.

**A Family Healing Center has a detailed document called the "NOTICE OF PRIVACY PRACTICES". It contains more information about the policies and practices protecting the patient's privacy including other potential disclosures and uses of patient's health information. I understand that I can receive a copy of this document at any time of my choosing. The document is also available on our website at [painstc.com](http://painstc.com). I understand that I have the right to read the "NOTICE OF PRIVACY PRACTICES" before signing this Acknowledgment.**

A Family Healing Center may update this Acknowledgment and "Notice of Privacy Practices". If I ask, A Family Healing Center will provide me with the most current "Notice of Privacy Practices". Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be it by specified methods of communications or alternative locations.

A Family Healing Center has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist A Family Healing Center by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

Patient/Responsible Party Signature \_\_\_\_\_

Date: \_\_\_\_\_



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## Financial Policy, Consent for Treatment, Release of Medical Information

Thank you for choosing A Family Healing Center as your health care provider.

**You and your insurance carrier are responsible for your bill. Knowing our insurance plan benefits is your responsibility.**

The following are the financial terms of this office. Your signature below signifies your acceptance of these terms as a condition of the services rendered and your receipt of a copy of this agreement. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our financial policy.

**Insurance information must be presented/updated at the time of making your appointment** not at the time of service. Most insurance companies have requirements for authorization of services and/or referrals from the Primary Care Provider prior to the services. If you present for your appointment and you have not provided your correct insurance to ensure verification, authorization of services and all required referrals, you will not be seen and your appointment will be rescheduled.

**Payment in Full for non-insurance services is expected at the time of service.** Co-payments, co-insurance and deductibles for services are required at the time of registration. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment/insurance and deductible at the time of service. If you arrive without the ability to pay for your services or your co-pay you will not be seen and your visit will be rescheduled and a fee assessed.

**If you have insurance, as a courtesy to you, we will file your primary and secondary insurance claim for services at no cost to you.** However, we will not wait more than 45 days from date of service for the insurance to pay. After 45 days, unpaid charges become your responsibility to pay to us immediately, and it is your responsibility to contact your insurance company and follow up on why your claim has not been paid. You must take the necessary action required to get your claim paid and communicate your actions to our office in writing. Failure to assist our office in timely payment of your insurance claim will result in the total charges being transferred to patient liability. Any patient liability assigned to you by your insurance carrier will be billed to you. Once insurance has paid, payment in full of the patient assigned liability will be expected with the receipt of your statement. You will receive two billing statements regarding your balance. If we do not hear from you after these two statements, your account will be subject to our collection process unless prior arrangements are made with our financial office.

**Medicare:** We are unable to bill Medicare or order any test or lab work to be billed to Medicare. If you have Medicare you will be a self-pay patient for any office visits, tests or labs by our doctors.

**We're committed to providing the highest quality care for our patients** and we charge what is usual and customary for our area. You are ultimately responsible for all clinic fees relating to your care. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company

**Not all services are a covered benefit in all contracts.** Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. Your policy may also contain plan specific limitations that apply to referrals, referral dates and number of visits. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee our accuracy in confirming your coverage or payment from your insurance carrier, nor a release of your liability in paying your bill. The contract of coverage is between you and your insurance carrier and it is your responsibility to understand your coverage, coverage requirements and limitations due to the variations between policies. You will be expected to pay for the patient liability assigned to you by your insurance carrier.

**For services that are not covered by insurance,** the practice requires payment of 100% of the total estimated charges unless prior payment arrangements have been set up with our office.





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**Self-Pay and Insured individuals electing to be self-pay.** The patient may elect not to file their health insurance and elect to be a self-pay patient for services provided IF THE INSURANCE COMPANY IS OUT OF NETWORK. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patient will not be able to file their health insurance for the services due to insurance claim submission requirements. A Family Healing Center will not file insurance for any services where the patient elected to be self-pay. The patient's election to not file the services to their insurance company does not affect or reduce any out of pocket financial responsibility for future services as determined by their insurance plan. **Your charges are due in full at the time of service in which you will receive a 20% discount.**

**If you do not have insurance** coverage for the service, are self-pay, or have insurance that A Family Healing Center does not participate in or accept, payment is expected at the time of service. A Family Healing Center has established a 20% Day of Service discounted self-pay rate. Prior financial arrangements must be made and approved before your visit if you cannot pay 100% at the time of service.

**No discount of assigned insurance patient liability** (co-pay, deductibles, co-insurance) will be made, to comply with our contracts with insurance payers, and federal / State of Oregon insurance regulations and law.

**If financial arrangements have not been made and you arrive without the ability to pay for the services you will not be seen and your visit will be rescheduled and a \$50 missed appointment fee assessed.**

**Out of Network Insurance**- Some insurance plans require you to pay different out-of-pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. It is your responsibility to inquire about any plan specific coverage limitations with your insurance company. You can choose to have the services performed as "Out of Network" or as self-pay.

**Insurance information provided after the services have been provided** will be billed or not billed at the discretion of A Family Healing Center. Due to the Insurance contractual requirements for referrals, authorization of services and timely filing limitations, insurance must be presented prior to services being provided. If A Family Healing Center agrees to bill your insurance you will be held liable for the charges if the insurance denies your claim as untimely because of late presentation of coverage or for lack of timely authorizations or referrals.

**Late Payment and Collection Fees:** You agree to pay the higher of a minimum \$30 monthly late payment fee or up to a 3% monthly compounded interest on all unpaid charges that are not paid within 45 days of the encounter date. If your account is turned to a collection agency a 40% add-on fee will be applied. You agree to pay all reasonable Collection, Court and Attorney's Fees we incur in the collection of your debt. These accounts may be reviewed for assignment to an outside collection agency for collection. If legal action is taken to collect any amounts owed, the prevailing party shall be entitled to recover their reasonable attorney fees

**Account Closure:** Past due accounts may be considered closed without further notice. We reserve the right to decline to provide any further services until the closed account is paid in full or appropriate payment arrangements are made.

**Returned checks and Declined Credit and Debit Card Charges** are subject to a handling fee of \$36.00 per occurrence plus card processor charge-back charges.

**Credit and Debit Card Payments reversed** (charged back to us) by patients will incur a \$36 charge in addition to any fees charged by your or our credit/debit card processor. Our receipt of this fee notice is the only notice we need to receive, the charges will be placed on your statement, and future appointments will be cancelled until fees are paid.

**Multiple Accounts:** We reserve the right to apply overpayments from one account to a remaining balance on another account with the same guarantor.

**Family Expenses:** According to Oregon law, a spouse is financially responsible for family expenses incurred by the other spouse or for the benefit of their minor children or stepchildren. It is agreed that all charges incurred or fees imposed according to this agreement are family expenses for which both spouses/parents are financially responsible.





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**Communication Consent:** You agree, in order to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing. Your consent to these communications applies to those communications initiated by our office or by an agent, attorney, or collection agency acting on our behalf.

**Payment -** Payment for all supplies, lab fees and supplements are due and payable at the time of service. Patients without insurance pay in full at the time of service. Most blood tests are paid for at the time of service or are billed to your insurance company. If you do not have insurance, blood tests must be paid for at the time of service. Our office accepts Visa, MasterCard, and personal checks. Our office does not accept cash, Discover or American Express. Please call 24 business hours in advance to cancel an appointment. If you do not call to cancel, you will be billed a \$50 cancellation/no show fee for return patients and \$115 for new patients. If you provide a credit card upon scheduling, it will be billed the same day the appointment is missed. If you have 3 no shows or cancellations without 24 business hours' notice, your care may be terminated. Patient balances over 30 days will be charged a minimum \$30 Late Fee or 3% monthly compounded interest.

**Procedures for No Shows, Late Arrivals resulting in Appointment Cancellation and Late Patient Cancellations**

**\*MEDICAID PATIENTS CAN NOT BE BILLED FOR NO SHOW or MISSED APPOINTMENT FEES\***

**Late Arrival to Appointments Defined:** We make every attempt to stay on schedule, to help us please be on time. Your appointment will be cancelled if you are 15 minutes late.

**Fees We Charge for No Shows, Late Arrivals resulting in Appointment Cancellation and Late Patient Cancellations.**

- You agree that there will be a:
  - \$115.00 charge for new patient appointments, and a \$50 fee for returning patient appointments
  - All future appointments will be cancelled and will not be rescheduled until payment of No Show, Late Arrival and Late Patient Cancellation fees are made.

**Patients that miss three (3) appointments (No Show, Late Arrival or Late Cancellations) are subject to dismissal from the Clinic.**

**Medicinal Returns:** We are unable to give refunds or credits on tinctures, gemmos, or homeopathics; opened or unopened. By law, A Family Healing Center cannot re-sell these un-sealed products.

**Litigation:** Patients involved in law suits are, as others, are responsible for timely payments of charges incurred. We require monthly payments to be made by the patient.

**Worker's Compensation Claims:** Patients filing worker's compensation claims (on-the-job) do not pay for services directly related to the accident or illness. The employer's insurance carrier is billed weekly. It is your responsibility to record dates of services and mileage to and from A Family Healing Center to apply for mileage allowance. We recommend you keep a daily log of expenses and symptoms.

**Motor Vehicle Claims (MVA):** IF THE PROBLEM FOR WHICH YOU ARE SEEING US INVOLVES LITIGATION, SUCH AS AUTO ACCIDENT, PLEASE BE ADVISED THAT WE DO NOT WAIT FOR PAYMENT UNTIL LITIGATION IS SETTLED, BUT WILL EXPECT REGULAR MONTHLY PAYMENTS ON THE ACCOUNT TO BE DETERMINED AFTER YOUR INITIAL APPOINTMENT. WE REQUIRE A COMPLETED MVA INFORMATION FORM, A COPY OF YOUR MOTOR VEHICLE INSURANCE POLICY AND A COMPLETED RELEASE OF INFORMATION FORM,

**Reinstated Care:** Unless you are under current care in this office (within the past six months) an examination may be necessary to reinstate proper treatment. Each new injury or chief complaint requires an examination due to the possibility of structural changes or a change in diagnosis.

**Personal Hygiene:** For health considerations and due to the close interpersonal nature of our work, your personal cleanliness is required for a comfortable environment. NO SMOKING or other strong aromatics please.

**Accordingly (Initial each statement):**

\_\_\_\_\_ I have read and understand the notice of privacy policies of A Family Healing Center.

\_\_\_\_\_ I understand that insurance may not cover certain diagnostic tests, procedures, IV Therapy, or supplements that may be prescribed by the doctor and I agree to pay for these costs at the time of visit.

\_\_\_\_\_ I have read the policies above and agree to be financially responsible for services provided by this office.



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**AUTHORIZATION:**

I hereby authorize A Family Healing Center to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to A Family Healing Center. In the event my insurance makes payment directly to me for services I will immediately endorse and assign the payment to A Family Healing Center. If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I give A Family Healing Center permission to appeal any denials by my insurance for services rendered on my behalf. I will assist A Family Healing Center with follow up of timely payment, requests for information and appeals to my insurance as necessary to ensure full and timely payment for services received. I further agree that a photocopy of this agreement shall be as valid as the original.

**PATIENT ACKNOWLEDGEMENT OF AGREEMENT:**

I have read the A Family Healing Center Financial Policy and Consent for Treatment, policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

**If the patient is a minor, permission is given by me to the doctors of this office to treat my child.**

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(Patient/Responsible Party) Signature

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(Patient/Responsible Party) Printed Name

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Date



# HEALTH HISTORY

Patient Name : \_\_\_\_\_ Birthdate : \_\_\_/\_\_\_/\_\_\_ Todays date: \_\_\_\_\_

Primary care physician: \_\_\_\_\_

Please list all medicines you are currently taking (including non-prescription drugs): \_\_\_\_\_

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## Goals for Treatment

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

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**Past Medical History** such as cancer, diabetes, ear infections, eczema, accidents, injuries, mono infection surgeries, organ removals, etc...(please list dates of occurrences)

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**Family History** such as cancer, diabetes, heart disease, stroke, migraines, mental illness, or autoimmune condition (please state who in the family had these conditions)

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Habits such as alcohol, coffee, smoking, etc... \_\_\_\_\_

Exercise: \_\_\_\_\_

**MEN ONLY:** circle "yes" or "no" or leave blank

Urination changes or difficulties....yes no Night urination....yes no Sexual dysfunction....yes no

**WOMEN ONLY:** circle "yes" or "no" or leave blank

**Do you plan on getting pregnant in the next year?**

**Do you currently use birth control? Yes No, if yes which type: Pill, IUD, Implant, Injection,**

**Other** \_\_\_\_\_

Problems with menstrual cycle...Yes No, If yes: \_\_\_\_\_

Vaginal itching or discharge...Yes No Numbers of pregnancies: \_\_\_\_\_ Live births: \_\_\_\_\_

Hot flashes or night sweats...Yes No If yes, how many per day? \_\_\_\_\_

To the best of my knowledge, the above information is correct. I understand that giving inaccurate information may harm my (my child's) health. It is my responsibility to inform the doctor of any changes in my or my child's medical status. I authorize the health care staff to perform necessary health care services.

Patient's signature: \_\_\_\_\_