

Female Patient Registration Form

Dr. Jillian Shannon, ND, NMD

Modern | Apothecary

Integrative Medicine

Anti-Aging and Regenerative Medicine



Last Name:		First Name:		MI:	
Address:					
City:		State:		Zip:	
Cell Phone:		Home Phone:		Join our mailing list? (Yes) / (No)	
Phone# where we may leave private medical information? (Circle one) Cell or Home or both				Date of Birth:	
Email Address:					
Primary Care Physician:				Phone #:	
Employer:				Occupation:	
Emergency Contact:		Relation:		Phone#:	
Allergies:					
HEALTH INSURANCE COMPANY: (List all insurances – Primary, Secondary, Tertiary)					
How do you hear about Modern Apothecary Integrative Medicine?					
*Radio *Newspaper *Yelp *Coupon *Magazine *Internet Search *Direct Mail					
*Physician Referral *Friend/Family (Please list person) *Facebook *Other					

Patient Signature

Date

PATIENT INTAKE FORM

Date: _____

Patient Name: _____ DOB/Age: _____

List your health concerns in order of importance:

1. _____
2. _____
3. _____

Current Diagnosed Health Conditions:

1. _____
2. _____
3. _____
4. _____
5. _____

Past diagnosed health condition:

1. _____
2. _____
3. _____
4. _____
5. _____

List All Surgeries & Hospitalizations, including date occurred:

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications (indicate name of drug, dose, and how often you take it. If none, write none):

Current supplements (Vitamins, mineral, herbs, fish oil, etc):

Allergies: Any known drug allergies, food allergies, or environmental allergies?

Family history:

Please circle any of the following illnesses/diseases if you have had an immediate family member (Mother, father, sibling, child, grandparents) with that/those condition(s):

<ul style="list-style-type: none">• Cancer• High blood pressure• Heart attack• Stroke	<ul style="list-style-type: none">• Diabetes mellitus• Allergies• Asthma• Autoimmune disease	<ul style="list-style-type: none">• Mental Illness• Osteoporosis• Lung Disease• Thyroid Disease
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NEXT place an abbreviation next to the disease listed above indicating the family member who suffers or suffered from this:

<ul style="list-style-type: none">• Mother = M• Father = F	<ul style="list-style-type: none">• Brother=B• Sister=S• Child=C	<ul style="list-style-type: none">• Maternal grandmother=MGM• Maternal grandfather=MGF• Paternal Grandmother=PGM• Paternal Grandfather=PGF
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Social History

• **Smoking?** Yes No **How many packs per day? _____ How many years?**

• **Alcohol?** Yes No **How much and how often, if yes/past?**

• **Soda/Pop?** Yes No **Past Ounces per day if yes/Past**

• **Illegal drug** Yes No **Past What drug if yes/**

Past _____

• **Treated for substance abuse of any kind ?** Yes No **When?**

Review of Systems

• **Do you have low energy or fatigue?** Yes No

• **Present Weight:**_____ **Weight One Year Ago:**_____ **Height:** _____

• **Ideal Weight:**_____

of Bowel Movements Per Day? _____

of Hours of Sleep Per Night? _____

Dental History

<ul style="list-style-type: none">• Root Canals? Yes No	<ul style="list-style-type: none">• # of Root Canals:
<ul style="list-style-type: none">• Mercury Amalgam tooth fillings? Yes No	<ul style="list-style-type: none">• #of mercury fillings:
<ul style="list-style-type: none">• Dental Crowns? Yes No	<ul style="list-style-type: none">• #of dental crowns:

Please list issues you may have regarding each category or leave blank if not applicable:

Skin:	
Head/Neck:	
Respiratory (Lungs):	
Cardiovascular (Heart/Blood Vessels):	
Gastrointestinal/Digestion:	
Urinary:	
Female Reproductive:	
Male Reproductive:	
Musculoskeletal (Muscles/ Skeleton/Joints):	
Neurologic (Nervous System)	
Psychiatric (Mental Health):	

FEMALE GENITALIA

Menstrual Cramps	Menstrual Pain	Pain with intercourse	Hot Flashes
Heavy Menstruation	Irregular Menstrual Cycle	Decreased Libido	Night Sweats
PMS	Missed Menstrual Periods	Vaginal Dryness	Fibrocystic Breast
PCOS (Polycystic ovarian syndrome)		Uterine Fibroids	Sexually active

Last Menstrual Period (date)? _____

How many days in-between menstrual cycles (i.e. 21, 28, 30, 35 etc)?

How many days does period last?

Last Pap Smear?

Any abnormal pap smears or history of HPV (Human papilloma virus)?

Yes No Both

Mammography?

Yes No

If yes, when was the last mammogram?

Bone density test?

Yes No

If yes, when was the last bone density test?

Any history of STDs (Sexually transmitted diseases)?

Yes No

If yes, what disease?

#Times pregnant?	#of Births? Year?	#of miscarriages?	#of abortions?
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Types of birth control used and ages used? Circle type and then specify ages/# years used.

Condoms	Birth control pill	IUD (intrauterine device)	Tubal ligation ("tubes tied")
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Hysterectomy? Yes No

If yes, then circle which type below and specify reason for hysterectomy in this space::

Total hysterectomy (uterus and both ovaries removed)	Partial hysterectomy (only uterus removed, ovaries still remain)
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Welcome to Modern Apothecary Integrative Medicine! We look forward to helping you achieve your health goals. This document contains important policy information that pertains to your treatment. Please read over the entire document. If you have any questions please feel free to ask us.

Appointments

Kindly provide 24 hours notice if you need to cancel or reschedule an appointment. Canceled or rescheduled appointments without appropriate notice will be assessed a fee of \$100 for new patient consultations, \$50 for established patient visits and \$25 for all other services. We understand that emergencies do occur, and as a courtesy will allow one late-cancel or missed appointment at no charge. Following the first missed appointment we will be asking you for a credit card to hold your future appointment(s). Please note that insurance companies do not reimburse for missed appointments.

Payment

Modern I Apothecary Integrative Medicine requires payment in full at the time services are rendered. I also understand that upon my request the cost of all procedures and services will be told to me before they are performed. For your convenience we accept Check, Cash, Visa, MasterCard or American Express payments. There will be a \$150.00 fee for all returned checks. **All cash paying patients will receive a 5% discount.**

Retail Return Policy

All supplement and other retail sales are final.

Refunds and Credits

Payment for services rendered is non-refundable. Payment for pre-paid services may be returned as a credit to your patient account at Modern Apothecary. Patient account balances may be used for any service or products offered at Modern Apothecary. Any credit issued has no cash value.

Emergencies

If you have a true medical emergency or serious medical concern please call 911 immediately. If you have a non-emergency health concern please call the office between 10am and 6pm M-F, or between 10am and 4pm Sat. We will schedule you as soon as possible to speak with/be seen for a medical visit by Dr. Jillian Shannon. A staff member from the clinic or the doctor directly will return your phone call to you within 48 hours.

I have read this document completely and I understand and agree with all of its contents demonstrated by my signature below and my initials above.

Signature of Patient or Pt. Representative: _____ **Date:** _____

Informed Consent to Treat

Consent: I voluntarily consent to outpatient care provided by Dr. Jillian Shannon encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies including imaging studies), Intravenous therapies, injections, acupuncture, and administration of medications prescribed by the doctor. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment. I understand that not ALL of the treatment suggestions provided are accepted by the United States FDA and therefore should not be taken as such.

Type of Care: I understand that this medical practice uses some diagnostic and treatment methods that are variously known as, but not limited to: Naturopathic, environmental, complementary, alternative, integrative or nutritionally oriented. I agree to treatment using, but not limited to, nutrition, lifestyle, homeopathy, ozone therapy, manipulation, herbs, chelation therapy, acupuncture, pharmaceuticals, and intravenous and injection therapies.

Recital of Risks: I understand and am informed that, as in the practice of naturopathic medicine/ medicine, there are some risks to treatment, including, but not limited to: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness, allergic reactions to prescribed herbs, supplements, medications, aggravations of pre-existing symptoms.

Notice to all pregnant women: All female patients must alert their physician if they have a confirmed or suspected pregnancy as some of the therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pace maker and /or cancer, for your safety it is vital to alert your physician of these conditions.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

No Guarantee: I understand that results are not guaranteed.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I understand that this consent form will be valid and remain in effect as long as I receive medical care provided by Dr. Jillian Shannon.

Patient or Pt. Representative Signature

Date

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**PRIVACY PRACTICES ACKNOWLEDGEMENT
ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices and I have been provided an opportunity to view it.

Name: _____

Birth date: _____

Signature: _____

Date: _____

