Family and Environmental Medicine

68 Old Stamford Road
New Canaan, CT 06840
Phone 203-966-6360 • Email drgruber@sciencemeetsnature.com

NEW PATIENT HISTORY

Name: _____ Date: _____
Do you have a nickname you prefer to be called by? _____
Age: _____ Date of Birth: _____ Male/Female _____ SS# _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone # (Home): _____ (Work): _____
Occupation: _____ Email: _____
Single/Married/Committed Relationship/Divorced/Separated/Widowed
Who may be call in case of an emergency? _____ Phone# _____
What illness or condition brings you to this office?

_____
_____
_____
_____
_____
_____
_____

Are you under treatment of any kind for this illness or condition? If so, indicate the nature of the treatment:

_____
_____
_____
_____
_____
_____
_____
_____

Have you ever been hospitalized and if so, when, and for what condition?

_____
_____
_____
_____
_____

Are you currently under the care of a medical doctor? If so, please list his/her
Name _____
Address _____
Nature of any condition for which you are being treated:
_____
_____
_____
_____

Please circle any conditions for which you have been diagnosed or treated;
Indicate (P) for PAST or (N) for NOW or (B) for BOTH:

Anemia
Eczema
Liver Disease
Poor Memory
Arthritis
Epilepsy
Lyme Disease
Fatigue
Asthma
Gout
Mononucleosis
Acne
Bleeding
Hay Fever
Pneumonia
Heart Disease
Cancer (Type)

Headaches
Seizures
High Blood Pressure
Colitis
Heart Murmur
Sinusitis
Menstrual
Constipation
Herpes
Thyroid Disease
Diabetes
Injury
Tuberculosis
Digestive Disorder
Kidney Disease
Depression

Do you have any allergies? Yes: _____ No:_____
To medications? Yes: _____ No:_____
List: _____
_____
_____
To environmental elements (pollen, molds, animals)? Yes: _____ No:_____
List: _____
_____
Foods?
List: _____
_____
_____
Anything else?
List: _____
_____
_____

Have you ever had an adverse reaction to medication? Yes:_____ No:_____
If Yes, what medication and what was your reaction?

_____
_____
_____

Do you exercise? Yes:_____ No:_____
If yes, what kind and how often: _____
_____

How many hours of sleep do you get a night? Hours:_____
Do you sleep well? Yes _____ No _____
Do you wake rested? Yes _____ No _____

Please list the typical foods you like for:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Liquids (types and amounts): _____
_____

Do you have any history of major trauma? Yes _____No _____
If yes, please explain:

_____
_____
_____
_____
_____

Please list your health concerns in order of importance to you:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any medications you are taking, including over the counter:

_____
_____
_____
_____

Please list any vitamins or supplements which you take:

_____
_____
_____
_____

Please list any other information about your health you would like to add:

_____
_____
_____

Do you have children? If yes, please list by age"

_____
_____
_____
_____

How did you hear about this practice?

_____
_____
_____
_____

By signing below, I acknowledge that the information given in this NEW PATIENT HISTORY is accurate and correct to the best of my knowledge.

_____ _____

(Patient or Legal Guardian Signature) (Date)

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Release of Information

I authorize the physician to provide from my records any and all information requested by my Insurance Company, Medicare, Medicaid, or other third party payer, in connection with payment for my incurred charges. I also authorize the physician to provide any quality review organization affiliated with my insurer the information it requests for use in utilization management/review.

Assignment of Benefits

I understand I am always responsible for payment regardless of the insurance coverage I may have. I assign any insurance benefits to which I may be entitled to the physician providing the services. I understand that I am responsible for any charges not covered by this assignment. I authorize release of any medical or other information necessary to process my insurance claims. I understand that Medicare does not cover naturopathic services. Co-payments are due at the time of the visit. I understand that I will be charged for services not covered by insurance based on the Schedule of Fees for Office Therapies, Treatments, and Assessments, a copy of which I have received. Some plans may require a referral from the primary care physician and such referral is the patient's responsibility. Reimbursement from other insurance companies for which the physician is not a provider is the responsibility of the patient and a bill will be provided upon request. I authorize disclosure of records to my insurance carrier, attorney, or referring practitioner.

Patient Privacy Agreement

I give the physician authority to share with any consultant all information deemed necessary to coordinate my medical care. This includes sharing, mailing, faxing information such as office notes, EKGs, laboratory results, radiology reports, medication lists and other consulting notes to physicians, hospitals, pharmacists and insurance companies. The signature below also gives such authority for an individual or a minor for whom the signor is legally in charge.

_____ _____

(Patient or Legal Guardian Signature) (Date)

_____

(Print name)

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INFORMED CONSENT TO NATUROPATHIC CARE

I have had an opportunity to discuss with my physician the nature and purpose of naturopathic care and I hereby request and consent to the performance of naturopathic procedures including:

- Physical examination
- Diagnostic testing
- Natural supplements and homeopathic remedies
- Botanical medicines
- Hydrotherapy
- Acupuncture
- Electrotherapy
- Phototherapy
- Articular manipulation
- Dietetics
- Mechanotherapy

I understand and am informed that there are some risks to the examinations and treatments.

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, supplements, prescribed medication, prescribed exercises and lifestyle modification will increase the effectiveness of my care and enhance or maintain the results. I understand the referral to another physician or specialist may be necessary due to the nature of my condition and limitations in the scope of practice of Naturopathic Medicine.

I understand that the scope of practice of a Naturopathic physician licensed in the State of Connecticut has limitations including no prescription privileges and no hospital privileges. Consequently a referral to a specialist or emergency room may be deemed necessary under certain circumstances and in my best interest.

Furthermore, I understand that some treatments and examinations may involve areas that are both sensitive and private. The doctor will exercise the highest level of care during such procedures, including draping. If at any time either before or during treatment I am uncomfortable with a procedure in these areas I will verbally inform the physician and a written note will be documented in my chart.

I do not expect the physician to be able to anticipate and explain all the risks and complications, and I wish to rely on the physician to be able to exercise judgment during the course of the procedure based on the facts known.

I have read, or have had read to me the above consent. I have had an opportunity to ask questions about its consent, and by signing below I agree to

the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. The signature below also gives such authority for an individual or a minor for whom the signor is legally in charge.

_____ _____

(Patient or Legal Guardian Signature) (Date)

_____

(Print name)