Health History Form

First Name Last Name

Date of Birth mm / dd / yyyy

Street Address

Address Line 2

City State

Postal Zip Country

Phone Number Cell Number

Email

Emergency Contact:

First Name Last Name

Phone Number Relationship

Reason for Visit

Last Physical Exam

Allergies/ Sensitivities:

Are you in frequent contact with harmful chemicals? _____

List of major causes of stress: **Level of Stress:** 1 2 3 4 5

How did you hear about us or who referred you?

Patient HIPPA Consent Form

I understand that I have certain rights of privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day health care operations of your practice.
- Consent to leave voicemails regarding appointments, and patient information at listed phone number on chart
- Consent to talk to someone other than patient regarding treatment and appointments. YES or NO (If, yes, please list approved personal and relationship)

Do you give consent? YES _____ NO _____

Approved list of individuals whom we can talk to regarding treatment and appointments.

Person	Relationship
Person	Relationship
Person	Relationship

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my right under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected heath information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use disclosure that occurred prior to the date I revoke this consent is not affected.

Date mm / dd / yyyy

Patient Name	Signature