Patient Intake Form

CONFIDENTIAL

Dr. Kathryn J. Hahn, D.O.M.
1925 Aspen Dr. Suite 502 B
Santa Fe, NM 87505
505-216-5077

Name:

Phone:

Date of Birth:

Email:

Address:

SS#*:

Street Address:
City, State:
Zip Code:

*for insured patients only

Occupation:

Emergency Contact:

Name:
Relationship to Patient:
Phone Number:

Marital status:
___ Single ___ Married
____Divorced ____Widowed
_____Partnered

Number of Children: _____

Any chance you may be pregnant? (females only)_
___Yes _____ No

Physician's Name and Phone Number:

Do you have Health Insurance? ____ Yes _____ No

Name of Insurance Carrier _____

Does your insurance cover acupuncture? ____ Yes _____ No

Name of Primary Insured (If someone other than the patient):_____
Primary Insured DOB:___/_____/_____
Primary Insured SS#: _____

Have you ever been treated with acupuncture before? _____ Yes _____ No

Who should we thank for referring you to this office?_____

Please check all that apply: Is it acceptable to leave a message regarding your care at:

_____Home _____Work _____Cell _____Email

Your Concerns

In order of importance, please list and describe the top three issues for which you would like my help.

1.

2.

3.

Are ANY of these issues as a result of an AUTO or WORK related accident? If yes, please explain:

How long ago did these problems begin?

Have you been given a physician's diagnosis for these problems? If so, what are they?

What treatment have you tried for these problems?

Are you currently receiving treatment for these problems? If so, what type of treatments?

Through what methods do you expect to be treated? (Please circle all that apply.)
Acupuncture / Physical Therapy / Nutritional Supplementation / Herbal/Homeopathy/
Diet and Nutrition / Lifestyle Change

What would you consider to be a successful result of your treatment?

What would be an excellent result of you treatment?

What would be a miraculous result?

Past Medical History

Illness:

Surgeries:

Significant Trauma (i.e. Car Accident, Fall, etc.):

Do you have or have you ever had any infectious disease (i.e. hepatitis, tuberculosis, HIV)?
If so, please describe:

Medicines: Include prescription, over the counter drugs, vitamins, or herbs taken in the last 3 months:

Allergies:

Family Medical History

Mother's Side:

Father's Side:

Have you had any unusual stresses lately?

Do you have a regular exercise program? Please describe:

Do you smoke? ____ Yes _____No # of cigarettes per day _____

Have you traveled out of the country this past year? If so, where?

Personal Medical History

Please check if you have EVER had any of the following:

	Cancer		Seizures		Diabetes		Rheumatic Fever
	Hepatitis		Heart Disease		Thyroid Disease		Stroke
	Allergies		Weight Problem		Venereal Disease		Mental Illness
	Asthma		Herpes		High Blood Pressure		Other: _____

Please check if you have experienced any of the following symptoms in the past 3 months:

General Health

	Poor Appetite		Localized Weakness		Peculiar Tastes or Smells		Sweat Easily
	Fevers		Insomnia		Bleeding		Change in Appetite
	Fatigue		Strong Thirst		Weight Loss		Night Sweats
	Tremors		Poor Balance		Weight Gain		Depression
	Cravings		Chills		Joint Pain		Emotional Changes
	Headaches		Sudden Energy Drop		Hearing Loss		Bruise Easily
	Low Libido or Erectile Dysfunction						

Respiratory

	Cough		Coughing Blood		Phlegm		Shortness of Breath
	Wheezing		Bronchitis		Asthma		Easily Winded

Gastrointestinal

	Nausea		Belching		Bloating		Abdominal Pain
	Diarrhea		Constipation		Black stools		Blood in Stools
	Vomiting		Indigestion		Hemorrhoids		Bad Breath
	Gastric Ulcers		Parasites		Intestinal Gas		

Genito-Urinary

	Painful Urination		Urgent Urination		Scanty Urination		Frequent Urination
	Blood in Urine		Impotence		Unable to Hold Urine		Frequent Night Urination
	Genital Sores		Kidney Stones		Discolored Urine		

Cardiovascular

	Blood Clots		Fainting		Cold Hands or Feet		Low Blood Pressure
	Phlebitis		Dizziness		Swelling of Hands		Chest Pain
	Swelling of Feet		Irregular Heartbeat		Difficulty Breathing		Cold Sweats
	Palpitations		High Blood Pressure				

Skin and Hair/Eyes, Ears, Nose and Throat

	Rashes		Itching		Change in Skin Texture		Ulcers
	Eczema		Hair Loss		Dandruff		Acne
	Recent Moles		Change in Hair Texture		Hives		Psoriasis
	Dizziness		Eye Pain		Earaches		Migraine
	Recurrent Sore Throat		Ear Ringing		Glasses		Glaucoma
	Eye Strain		Gum Problems		Sinus Problems		Poor Vision
	Grinding of Teeth		Sores on Lips		Night Blindness		Cataracts
	Floaters		Mouth Ulcers		Facial Pain		Blurred Vision
	Concussions		Spots in front of Eyes		Toothache		Jaw Clicking
	Poor Hearing		Nose Bleeds				

Gynecology & Pregnancy (females only)

	Irregular periods		Duration of flow _____		# of Pregnancies _____		Difficult Births
	Clots		Painful Periods		# of live Births _____		# of Miscarriages _____
	# of Abortions _____		# of Caesarian Births _____		Pre-Menstrual Syndrome		Currently Pregnant Due Date: _____
	Birth Control What kind: _____		Menopausal Symptoms				

I understand the information required and guarantee that this form was completed correctly and to the best of my knowledge.

_____ _____

Signature Date

_____ Adult Patient _____Parent or Guardian _____Spouse

Acupuncture or natural therapeutics are not meant to replace medical diagnosis or treatment. If symptoms are severe or persistent, you should always consult your physician.

I agree that if Kathryn J. Hahn, D.O.M. is billing a third party claim on my behalf, that I will pay her in full when the claim is settled.

I understand that there will be interest charges at the rate of 22% annually on any unpaid balance on my account, 30 days or greater past due. There is a $25.00 returned check charge on all returned checks.

When an appointment is made, the time is exclusively reserved. There will be no charge for appointments cancelled or re-scheduled at least 24 hours in advance. There is a $75 charge for any appointments not cancelled or re-scheduled 24 hours prior to your scheduled appointment. If you are 15 minutes late for your appointment, you must re-schedule and you will be charged a $75 re-scheduling fee.

I have read and understood the above conditions and policies. I agree to keep my Doctor of Oriental Medicine informed of any and all changes in my health.

Signed:_____ Date:_____

Signed (Practitioner):_____Date:_____

Patient Release of Information

ASSIGNMENT AND RELEASE OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign insurance payments directly to Kathryn J Hahn, DOM for services rendered. I understand that I am responsible for all charges whether or not they are paid for by insurance. (I, Dr. Kathryn J Hahn, DOM will make every effort to secure payment from your insurance company. In the event payment is not received within 90 days of services rendered you will be billed for the balance due.) I hereby authorize this provider to release information necessary to my insurance carrier, public payor, or individual to secure payment of benefits. I authorize this by the use of my signature below.

I, the undersigned, authorize Dr. Kathryn J. Hahn, D.O.M. to release therapeutic and medical information to the following individuals or insurance companies:_____

_____

_____ _____

Print Patient Name If Minor, Print Name of Parent/Guardian

_____ _____

Patient Signature If Minor, Signature of Parent/Guardian

SPECIAL FINANCIAL INFORMATION FORM

By my signature below, the full payment of my fees, co-pay and/or deductible would be a financial hardship for me.

Patient/Client Signature: _____

Date: _____

INFORMED CONSENT AGREEMENT

I hereby and consent to the performance of Acupuncture/Oriental Medicine procedures on me (or on the patient named below for whom I am legally responsible) by Kathryn J. Hahn, Doctor of Oriental Medicine.

I realize that there are some inherent risks from treatment by these procedures, including but not limited to bruising, bleeding, minor abrasions and/or burns or a possible temporary worsening of my symptoms.

I expect that the doctors will give me a verbal estimate of the number of times I may need, the frequency of the treatment, and the possible outcome of the diagnostic treatment or procedure. I do not expect the doctors or their representatives to be able to anticipate and explain all risks and complications, and I wish to rely on them to exercise their judgment to the best of their abilities during the course of my treatment.

I have had an opportunity to discuss with m doctor or therapist the nature and purpose of Acupuncture/Oriental Medicine and its procedures and potential outcomes. I understand the results are not guaranteed. I also understand that I shall have a choice to accept or reject the proposed diagnostic treatment or procedure, or any part of it.

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, agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions, and for future condition(s) for which I seek treatment by this office, its doctors and therapies.

PATIENT NAME **(DATE)**

PATIENT SIGNATURE/LEGAL GUARDIAN SIGNATURE **(DATE)**

OFFICE REPRESENTATIVE SIGNATURE **(DATE)**
