LivingWell
INTEGRATIVE HEALTHCARE
www.LivingWellHealthcare.com

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Welcome to LivingWell Integrative Healthcare. We congratulate you on beginning your journey to better health. We are honored to partner with you in achieving your wellness potential.

Patient Name:____ Date:

This is to confirm my appointment on ________________________at

with ____.

Please find your New Patient Information Packet attached. **Please read, complete, and sign all forms <u>prior to your appointment</u>. If you are not filling them in online, please bring them with your appointment.**

Please arrive **15 minutes prior** to your scheduled appointment, and bring all recent lab results and any medications or supplements that you are taking.

<u>Cancellation Policy:</u>
If you wish to cancel or reschedule your appointment, please notify our office at least **48 hours prior**, and we will assist you with this. Patients failing to show for an appointment or canceling less than 48 hours prior **will be charged the total cost of the missed appointment.** It is our office policy to confirm appointments by phone two days prior to appointments. Please provide us with your preferred contact information for appointment reminders.

We require a credit card to confirm your appointment at the time of scheduling and this first visit will be charged at that time. The credit card information will be kept confidentially in your chart.

Thank you for choosing LivingWell Integrative Healthcare!
Cheryl Middleton, PA-C
Andrea N. Wininger, MD, FACOG
James Clif Caldwell, MD

Demographic Information *Today's Date:*________________

Name: ____ *Date of Birth:* ________
LAST *FIRST* *MIDDLE*
Address: ____
STREET CITY STATE/PROV. ZIP CODE

*Telephone: Home: (____)*______________ *Cell: (____)*____________ *Work: (____)*
WITH AREA CODE

Email:

Employer: ____*Occupation:*

Driver's License No. ______________________________*Social Security No.*

Referred By:

Spouse's Name:

Marital History: Years married _________ *# Children:* ________ *Ages:*

EMERGENCY CONTACT: (Provide name & phone number)
*Name:*____________________________________ *Relationship to patient:*

*Phone: (___)*____

Primary Care Provider:

Other Physicians: ____

Patient Name:

Medical and Family History(check all that apply)

	Self	**First Degree Relative(who)**
Thyroid	____	______________________________
Prostate Cancer	____	______________________________
High Blood Pressure	____	______________________________
Heart Disease	____	______________________________
Diabetes	____	______________________________
Autoimmune Disease	____	______________________________
Kidney Disease	____	______________________________
Liver Disease	____	______________________________
Sleep Apnea	____	______________________________
Other	____	______________________________

List all surgeries you have had with dates:

Last Digital Rectal Exam/Prostate Exam: ________________

Last PSA blood test:____________________

Last Colonoscopy:_____________________

Patient Name:

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MEDICATIONS/SUPPLEMENTS: Please complete this medication form with any prescription or non-prescription medications, vitamins or other supplements.

Medication/ Supplement	***Form (pill, cream, etc,)***	***Dosage***	***Times per day***

ALLERGIES TO MEDICATIONS:

Name of Medication	***Symptom it caused***

Patient Name:

Social History/Lifestyle factors:

Diet:

Indicate how often:	*Never*	*Occasionally*	*Weekly*	*Daily*
Coffee/Tea				
Tobacco				
Alcohol (type)				
Artificial Sweetener				

Describe typical meal choices and approximate time each day:

Breakfast:

Mid-morning snack:

Lunch:

Afternoon snack:

Supper:

Evening snack:

Stress Level: *High*______________ *Moderate* __________________ *Low/None*

Average hours of sleep per night: ___________ *Sleep Quality:*

Average amount of water (glasses or ounces) consumed per day:

Exercise activities: (Indicate type of activity, duration, and times per week)

Patient Name:

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Symptom	Current	Past
Fatigue		
Burned out feeling		
Lack of Motivation		
Decreased strength		
Poor recovery from injury		
Joint pains		
Low sex drive		
Impotence		
Sleep problems		
Brain fog		
Irritability/Anxiety		
Weight gain		
Loss of muscle mass		
Headaches		
Salt/sugar cravings		
Cold hands/feet		
Dry skin/hair		
Acne/oily skin		
Emotional instability		
Heart palpitations		

What top 3 symptomatic improvements would increase your quality of life?

*1.*____

*2.*____

*3.*____

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Please Read the Following LivingWell Policies Carefully.

We are honored to partner with you in achieving your wellness goals. We recognize and value the trust that you have bestowed upon us. In order to preserve a great relationship with our patients, we're providing the following information concerning how we do business and how we can best provide healthcare services.

Payment Requirements: *Payment is expected for all services at the time of service. Your initial appointment will be charged to your credit card the day it is made. We gladly accept all major credit/debit cards.*

Insurance Information:
LivingWell Integrative Healthcare does not bill ANY insurance companies. None of our providers are "preferred providers" for any insurance company.
We work for you instead of an insurance company. Our goals are to provide services based on your individual healthcare needs, without a third party intruding on your healthcare choices. We will provide initial assistance in filling out a paper copy insurance reimbursement form (unless you have Medicare or Medicaid, see below). Please be aware that some insurance companies will not reimburse for our fees, and may not accept a paper form. If additional assistance is needed beyond the initial form, there will be a fee for this service.

Medicare/Medicaid please read the following information carefully:

All of our providers have "Opted Out" of Medicare. We are NOT Medicare providers and our services are NOT BILLABLE OR REIMBURSABLE TO MEDICARE/MEDICAID. Therefor you CANNOT file for reimbursement of any kind.

I have read, understand and agree with the above statements.

Please Print Name	*Signature*	*Date*