

Birmingham Integrative Health, P.C

Patient Name: _____ Social Security: _____

Date of Birth: _____ Sex: M/F (Circle one) Married/Single/Divorced/Widow

Address: _____

Primary Phone: _____ Secondary Phone: _____

Primary Care Physician: _____

How did you hear about our Practice? _____

IF PATIENT IS A MINOR

Parents Name: _____ Phone Number: _____

Emergency Contact

Name: _____ Phone Number: _____

Relationship: _____

Pharmacy (Name, Phone Number, Address)

Local: _____

Mail In: _____

Compounding: _____

Insurance Information

Plan: _____ I.D Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holders Social Security: _____

Policy Holders Date of Birth: _____ Sex: M/F

Copay: _____ Deductible: _____

(If it is a high deductible plan, with no copay, \$50 will be collected at each visit)

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to BIH. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

Personal Medical History (Please specify)

Acid Reflux	Heart Attack
ADD/ADHD	Heart Disease: _____
Addiction	High Blood Pressure
AIDS/HIV Positive	High Cholesterol
Allergies	Kidney Disease: _____
Alzheimer's/Dementia	Liver Disease: _____
Anemia: _____	Lung Disease: _____
Anxiety	Lyme
Arthritis: _____	Osteopenia/Osteoporosis
Asthma	Parkinson's
Cancer: _____	Seizure Disorder
Depression	Sleep Apnea
Diabetes: _____	Stroke
GI Disease: _____	Thyroid Disease
Headaches/Migraines	Other: _____

Preventative

Last Menstrual Period	Date: Normal Abnormal	PAP	Date: Normal Abnormal
Colonoscopy	Date: Normal Abnormal	Bone Density	Date: Normal Abnormal
Mammogram	Date: Normal Abnormal	Stress Test	Date: Normal Abnormal
Bone Density	Date: Normal Abnormal	Pneumonia Immunization	
Tetanus Immunization	Flu Immunization	Shingles Immunization	
Date:	Date:	Date:	

Family History

	Specify	Relationship
Cancer		
Dementia		
Diabetes		
Heart Disease/ Heart Attack		
High Blood Pressure		
High Cholesterol		
Stroke		
Thyroid Disease		

Are you seeing any specialists?

Name	Phone Number

What is the reason for your visit?

- Get Established with a primary care physician
 - Hormone imbalance
 - Thyroid Disorders
 - Weight Loss
 - Fatigue
 - Other
 - Trouble Sleeping
 - Acupuncture
 - Sick
 - Lyme
-
-

Please circle Current Issues

- Chills Fatigue Fever Weight Gain/Loss
- Blurred Vision Eye Pain
- Ear Pain Hearing problems Ringing in ears Sore Throat
- Chest Pain Palpitations
- Cough Shortness of breath Wheezing
- Abdominal Pain Acid Reflux Bloating Diarrhea Constipation Nausea Vomiting
- Painful urination Blood in urine Urinary frequency Urinary Incontinence
- Joint Pain Muscle Pain Back Pain Limb Pain
- Acne Mole Rash Itching
- Headaches Dizziness Tingling Tremor
- Excessive bleeding Easy Bruising
- Hair Loss Hot Flashes Night Sweats
- Anxiety Depression Difficulty Sleeping

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

Date: _____ DOB: _____

I acknowledge receipt of a copy of the current effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request MEDICAL RECORDS be sent to other physicians/facilities in the future.

Please **print** your name

Please **sign** your name

Email Address: _____ for Patient Portal Access

Please list any people who can have access to your health information: (This includes step parents, grandparents and any caretakers)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to confirm appointments, treatment and billing information via:

Cell Phone

Home Phone

Work Phone

I authorize information about my health to be conveyed via:

Cell Phone

Home Phone

Work Phone

Patient Portal

Any

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

CANCELLATION AND NO SHOW FEE

I acknowledge that there is a **\$50 fee** for missing my appointment or not cancelling or rescheduling **24 BUSINESS HOURS** before my appointment.

Name: _____

Signature: _____

Date of Birth: _____

Today's Date: _____

For HIPAA privacy complaints, please contact Business Manager Malcolm Lehr at 205-655-2110.