Birmingham Integrative Health, P.C

Patient Name: _____ Social Security: _____

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

Address:_____City, State, Zip _____

Primary (Cell/Home) Phone: _____ Secondary (Cell/Home) 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
ADD/ADHD
Addiction
AIDS/HIV Positive
Allergies
Alzheimer's/Dementia
Anemia: _____
Anxiety
Arthritis: _____
Asthma
Cancer: _____
Depression
Diabetes: _____
GI Disease: _____
Headaches/Migraines
Heart Attack
Heart Disease: _____
High Blood Pressure
High Cholesterol
Kidney Disease: _____
Liver Disease: _____
Lung Disease: _____
Lyme
Osteopenia/Osteoporosis
Parkinson's
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disease
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
Pneumonia Immunization Date:	**Tetanus Immunization Date:**	**Flu Immunization Date:**	**Shingles Immunization Date:**

Family History

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

Surgical History Please include Dates

_____
_____
_____
_____
_____

Social History

Marital Status Married Single Divorced Widowed
Number of Children _____
Tobacco: Never Quit _____ Yes, Type (vape, dip, cigarettes) _____ Amount_____ Years_____
Alcohol: Never Quit Rarely Weekly Daily
Recreational Drugs: _____
Sexually Active Yes No
Occupation: _____

Please list medications, vitamin, herbs, supplements you are currently taking

Name	Strength	How often do you take it?

Are you allergic to any medications?
No Known Yes (please specify and include what type of reaction)

_____
_____

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.