LONDON HEALTH CENTER 2376 Main Street Suite 3 • Ferndale, WA 98248 • (360) 384-2900 FAX (360) 384-2955

Thank you for selecting London Health Center for your health care needs. To help us provide you with exceptional care, please fill out this form completely. If you have any questions or need assistance, we will be happy to help you.

Personal Information

Legal Name:_____ Today's Date:_____

Wishes to be called:_____ Date of Birth: _____

□ Married □ Significant Other □ Single □Divorced □ Widowed □ Separated

Gender Identity: □ Female □ Male □ Neither □ Both □Other

Gender assigned at birth: □ Female □ Male □ Choose not to disclose

Contact Information: *Please check preferred phone number.*

□ Home Phone: _____ □ Work Phone:_____

□ Cell Phone: _____ Email : _____

Automated text/email okay: □ Yes □ No Is it o*kay to leave a message*? □ Yes □ No

Address: _____

City, State, Zip: _____

Employer:_____ Occupation: _____

In case of emergency, who should we contact? Name:_____

Relationship:_____ Cell #: _____ Home/work #:_____

Insurance Information *We will make a photocopy of your insurance card*

Primary Insurance_____ **Subscriber's Name**_____ **DOB**_____

Secondary Insurance_____ **Subscriber's Name**_____ **DOB**_____

Authorization and Release

I hereby authorize the direct payment of medical benefits to London Health Center, Inc. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize London Health Center, Inc. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.
I understand that charts will be shared if I am seeing more than one provider at London Health Center and information may be discussed between providers in this clinic.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

X_____

Signature of patient or parent if minor Date

A photocopy of these assignments shall be as valid as the original.

LONDON HEALTH CENTER 2376 Main Street Suite 3 • Ferndale, WA 98248 • (360) 384-2900 FAX (360) 384-2955

Health Questionnaire

Please fill out both sides of this form

Name:_____ Date of Birth: _____

REASON FOR VISIT: _____

GOALS FOR TODAY: _____

HAVE YOU EVER CONSULTED A NATUROPATHIC PHYSICIAN BEFORE? O Yes O No

FAMILY HISTORY

ADOPTED? O YES O NO If yes, please fill out information for biological relatives if known.

IF ANY IMMEDIATE FAMILY HAS HAD ANY OF THE FOLLOWING - PLEASE CIRCLE THE # AND INDICATE RELATIVE

1) ALCOHOLISM	7) CANCER (SPECIFY)	13) HEART DISEASE	
2) ALZHEIMER'S	8) CHOLESTEROL HIGH	14) HYPERTENSION	
3) ANEMIA	9) DIABETES	15) MENTAL ILLNESS	
4) ARTHRITIS	10) EPILEPSY	16) MIGRAINE	
5) ASTHMA	11) GLAUCOMA	17) OSTEOPOROSIS	
6) BLEEDS EASILY	12) HAYFEVER	18) THYROID	
OTHER:			

FATHER	Living? □ YES □ NO	Present health or cause of death:		
MOTHER	Living? □ YES □ NO	Present health or cause of death:		
SPOUSE	Living? □ YES □ NO	Present health or cause of death:		
BROTHERS	# Alive	Health:	# Deceased:	Cause of death:
SISTERS	# Alive:	Health:	# Deceased:	Cause of death:
CHILDREN	# Alive:	Health:	# Deceased:	Cause of death:

HOSPITAL ADMISSIONS (Not including pregnancies)

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

HEALTH HABITS AND OCCUPATIONAL HAZARDS

HEALTH HABITS: Check (√) which substances you use/have used and describe how much you use.	Do you eat organic foods?	Are you sensitive to:	OCCUPATIONAL: Does your work exposes you to the following:
O Drugs_____Year quit:_____	O Always	O Sugar	O Stress
O Nicotine_____Year quit:_____	O Often	O Caffeine	O Heavy Lifting
O Alcohol_____	O Occasion	O Chemicals	O Hazardous Substances
O Caffeine_____	O Never	O Perfumes	O Other:
O Soft drinks		O Medicines	

What foods (if any) do you exclude from your diet?

Additional Comments:

LONDON HEALTH CENTER 2376 Main Street Suite 3 • Ferndale, WA 98248 • (360) 384-2900 FAX (360) 384-2955

MEDICATIONS Please list

MEDICATIONS	DOSAGES	MEDICATIONS	DOSAGES
VITAMINS & SUPPLEMENTS	DOSAGES	VITAMINS & SUPPLEMENTS	DOSAGES

ALLERGIES TO MEDICATIONS (please list)

O Allergic to: Reaction to medication and approx date:

O No Known Allergies

MEDICAL HISTORY Mark C for current problems and P for past problems

Check (√) symptoms you currently have or have had in the past year.

GENERAL
- O Anxiety
- O Depression
- O Dizziness/Fainting
- O Fever
- O Forgetfulness
- O Headache
- O Loss of sleep
- O Loss of weight
- O Numbness
- O Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- O Arms O Hips
- O Back O Legs
- O Feet O Neck
- O Hands O Shoulders

GENITO-URINARY
- O Blood in urine
- O Frequent urination
- O Lack of bladder control
- O Painful urination

GASTROINTESTINAL
- O Appetite poor
- O Bloating
- O Bowel changes
- O Constipation
- O Diarrhea
- O Excessive thirst
- O Gas
- O Hemorrhoids
- O Indigestion
- O Nausea
- O Rectal bleeding
- O Stomach pain
- O Vomiting
- O Vomiting blood

CARDIOVASCULAR
- O Chest pain
- O High/Low bld pressure
- O Irregulr/rapid heart beat
- O Poor circulation
- O Swelling of ankles
- O Varicose veins

EYE, EAR, NOSE, THROAT
- O Bleeding gums
- O Blurred vision
- O Crossed eyes
- O Difficulty swallowing
- O Double vision
- O Earache/Ear discharge
- O Hay fever
- O Hoarseness
- O Loss of hearing
- O Nosebleeds
- O Persistent cough
- O Ringing in ears
- O Sinus problems
- O Vision - flashes/halos/other

SKIN
- O Bruise easily
- O Hives
- O Itching/Rash
- O Change in moles
- O Scars
- O Sores that will not heal

OTHER
- O Erection difficulties
- O Lump in testicles
- O Penis discharge
- O Sore on penis
- O Other

Last Colonoscopy:_____
O Normal O Abnormal
- O Abnormal vague bleeding
- O Breast lump or pain
- O Breast discharge
- O Extreme menstrual pain
- O Hot flashes
- O Painful intercourse
- O Vaginal discharge
- O Menstrual flow irregular
- O Miscarriages #_____

Last Pap:_____
O Normal O Abnormal

Last menses (1st day):_____

Last Mammogram:_____
O Normal O Abnormal

Check (√) conditions you have or have had in the past:

O AIDS	O Cataracts	O Heart Disease	O Measles	O Prostate Problem
O Appendicitis	O Chemical Dependency	O Hepatitis	O Migraine Headaches	O Rheumatic Fever
O Arthritis	O Chicken Pox	O Herpes	O Multiple Sclerosis	O Scarlet Fever
O Asthma	O Diabetes	O High Cholesterol	O Mumps	O Stroke
O Bleeding Disorder	O Emphysema	O HIV Positive	O Pacemaker	O Thyroid problems
O Breast Lump	O Epilepsy	O Kidney disease	O Pneumonia	O Tuberculosis
O Cancer	O Glaucoma	O Liver Disease	O Polio	O Ulcers

Additional Comments:

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any members of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

X_____

Signature of patient or parent if minor Date

LONDON HEALTH CENTER *2376 Main Street Suite 3 • Ferndale, WA 98248 • (360) 384-2900 FAX (360) 384-2955*

NOTICE OF PRIVACY PRACTICE SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

London Health Center, Inc. (the "Practice"), in accordance with applicable federal and state law, is committed to maintaining the privacy of you protected health information ("PHI"). In other words, information about your health condition and the care and treatment you receive from the Practice. We will use and disclose elements of your PHI in the following ways:

- Treatment
- Payment
- Health Care Operations.
- When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties.
- To organ, tissue and other donation organizations, upon or near your death if we have no indication about your donation preferences.
- Electronic Health Records are utilized through cloud based medical software that have the highest level of SSL/TLS encryption against malicious parties. We recognize that even high level encryption still has potential for malicious theft of your information.
- Because malicious electronic data theft is a rising issue, our office does not keep social security numbers or credit card numbers on file. We do keep your name and date of birth in our Intuit software for identification purposes. This information is password protected. We have google cloud backup of Intuit software that is also password protected. We keep uploads of insurance cards, intake information and patient letters on file for limited periods of time that are not password protected. We recognize anything electronic is subject to theft and we will not pay ransom for return of stolen information but will notify you if your information is stolen.

Special Cases:

- Appointment reminders, treatment alternatives and other health related benefits and services
- Office newsletter
- Sponsor of your health plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:

- **Restrictions**: To request access to all or part of your PHI. To do this, please make this request in writing. We are not required to grant your request.
- **Confidential communications**: To receive correspondence of confidential information by alternate means or location. To do this, please make your request in writing.
- **Access**: To inspect or receive copies of your PHI. To do this, please make your request in writing.
- Accounting: To receive an accounting of the disclosures by us of your PHI in the six years prior to your request. To do this, please make your request in writing.
- This notice: to get updates or reissue of this notice at your request.
- Complaints: To complain to our office or the US Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit this request in writing. The law forbids us from taking retaliatory action against you if you complain.

Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy Contact: To obtain more information on or have your questions about your rights answered: you may contact the Practice's Privacy Office, Dr. Angela London at London Health Center, Inc. 2376 Main Street, Ferndale, WA 98248.

Patient Acknowledgement: By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____	_____	_____
Patient Signature	Date	Print Patient Name