SARA OHGUSHI, N.D.

NATUROPATHIC PHYSICIAN & MIDWIFE
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CONFIDENTIAL PATIENT INFORMATION

Patient name______________________________Birthdate___________Age_____Gender____________

Address___________________________________City/State_____________________Zip___________

Best Contact Phone__________________________ Other phone ____________________________

Email__________________________________

Occupation_____________________________Employer_______________________________________

Marital Status____________Spouse/Partner_________________________Phone__________________

Emergency Contact Person_______________________________________Phone____________________

Relationship__________________

Insurance Co.______________________ Policyholder:______________________ DOB______________

Please allow us to copy your insurance card.

Authorization to treat (please initial):
_____I authorize Sara Ohgushi, ND to examine and treat me.
_____I understand that treatments and therapies recommended by Sara Ohgushi, ND may be different than those offered by other licensed health care providers and I am at liberty to seek other care.
Assignment and Release (please initial):
_____I hereby authorize my insurance benefits be paid directly to Sara Ohgushi ND, and I understand that I am financially responsible for non-covered services. I also authorize Sara Ohgushi ND to release any information required to process this claim.

______________________________________ ________________________
Signature Date

What are your top health concerns?

1)____

2)____

3)____

List any medications (prescription or over the counter) and/or vitamins/supplements you are taking:

____

____

____

List any known allergies to medications, foods or chemicals____

Are you currently under a physician's care?______If yes, physician's name___________________________

Last physical exam______________Last blood work______________Last dental exam________________

Women: Last gynecological exam__________________Last menstrual period_______________________

Number of pregnancies________Birth Control history__________________________________

Children (names & ages)____

How did you hear about my practice?____

(Continued on back....)

Past medical problems:____

____

____

Major illnesses/accidents/hospitalizations/surgeries:_______________________________________

____

FAMILY MEDICAL HISTORY

Please note the diseases or medical conditions that each of the following members of your family has or had. If they are deceased please note the age at which they died and the cause of their death.

Mother:____

Father:____

Paternal Grandmother:____

Paternal Grandfather____

Maternal Grandmother:____

Maternal Grandfather____

Siblings:____

____

HEALTH HABITS

Exercise: Type & Frequency____

Sleep: Average # of hrs_________ Do you wake rested?_____________

Tobacco:___Yes___No If yes, how much, how long?_____________________________________

Caffeine:___Yes___No If yes, how much, how long?_____________________________________

Alcohol:___Yes___No If yes, how much, how long?_____________________________________

Brief description of your diet:

____

____

____

Do you have any cultural or religious beliefs that you want me to know about to help me serve you better?

____

____

HIPAA (Health Insurance Portability & Accountability Act)
Privacy Practices Acknowledgment

I, **Sara Ohgushi ND**, respect and am vigilant in protecting patient confidentiality and the privacy of your health information. I am also required by law to maintain the privacy of your protected health information, to provide you with a HIPAA privacy practices notice and to abide by its terms.

You have a right to receive a paper copy of my HIPAA privacy practices notice upon request at any time. In signing this form you acknowledge that you have seen a copy of my HIPAA privacy practices notice (on paper and/or on my website) and you understand how your medical information may be used and shared with others involved in your healthcare. Should any of my privacy practices change, I will notify you that a change has been made if you are still in my current care.

If you have any questions about my privacy practices or HIPAA, please contact me. You have the right to file a complaint with me if you believe your privacy rights have been violated. I will not retaliate against you for filing such a complaint. If you feel my response is unsatisfactory you may also file a complaint with the Oregon Board of Naturopathic Medicine or the Washington State Department of Health.

________________________________	__________________________	____________________
Print name	Signature	Date

COMMUNICATION CHOICES

MOBILE PHONE: Do you give me permission to leave you messages on your mobile phone including your confidential health information such as lab results? ____yes ____no

TEXTING: Do you give me permission to text you confidential health information such as lab results? ____yes ____no Note: If you text me, your permission to text you back is implied. Please note that texting is NOT compliant with HIPAA law as it is not secure.

EMAIL: Do you give me permission to email you confidential health information such as lab results? ____yes ____no Note: If you email me, your permission to email you back is implied. Please note that my email is NOT compliant with HIPAA law as it does not have the required security.

SHARING INFORMATION: Do you give your permission for me to share your confidential information such as lab results or billing information with your partner or any other person? ____yes ____no
If so, who?______________________________________ Relationship________________________

________________________________	__________________________	____________________
Print name	Signature	Date