Dramov Naturopathic Medical Center

9735 SW Shady Lane, Suite 104 Tigard, OR 97223
www.DramovMedical.com

Patient Profile Questionnaire

NAME_____ AGE_____ BIRTHDAY_____ SEX _____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE (home) (_____)_____ (work) (_____)_____ (cell) (_____)_____

E-MAIL_____

GUARDIAN CONTACT INFORMATION _____

OCCUPATION & EMPLOYER_____(circle one) FULL TIME/PART TIME/RETIRED

EMERGENCYCONTACT: _____ RELATIONSHIP_____

ADDRESS: _____ PHONE#_____

HOW DID YOU HEAR ABOUT US? _____

A NOTE TO OUR PATIENTS: Preventive Medicine and holistic health care are only possible when the physician has a complete picture of the patient physically, mentally and emotionally. We are asking you to provide us with part of this picture by carefully and thoroughly completing this health history form. Print all information and mark any questions you do not understand.

You must understand that as Naturopathic physicians, we offer an approach to your overall care which may differ from other methods of diagnosis and treatment such as those offered by medical doctors, osteopathic physicians, etc. Our commitment is to provide you appropriate Naturopathic care and, to the extent possible, work with other health care providers equally concerned with your well-being. We are not medical doctors; we are not osteopathic physicians and will never attempt to take their place in your overall health management.

WEIGHT _____ HEIGHT_____ DO YOU EXERCISE? _____ TYPE? _____HOW OFTEN? _____

WHEN AND WHERE DID YOU LAST RECEIVE MEDICAL OR HEALTH CARE? _____

FOR WHAT REASON? _____

WHAT ARE YOUR MOST IMPORTANT HEALTH PROBLEMS? 1)_____ 2)_____ 3)_____

PLEASE LIST ALL CURRENT MEDICATIONS and/or SUPPLEMENTS:

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

9)_____ 10)_____ 11)_____ 12)_____

ARE THERE ANY PRACTITIONERS WHOM YOU WOULD LIKE US TO ATTEMPT TO COORDINATE CARE WITH?

1) _____ 2) _____ 3) _____

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Insurance information for Dr. Rob Dramov:

1. Insurance Company: _____
2. Subscriber Name: _____
3. Relationship to patient: _____
4. Subscriber DOB: _____
5. Group #: _____
6. Policy #: _____
7. Is the patient covered by additional insurance: _____
8. I, the undersigned, certify that I (or my dependent) have insurance coverage with

   _____ and assign directly to DNMC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

   _____
   Responsible Party Signature

   _____ _____
   Relationship Date

Patient Questionnaire

Patient's Name: Birth Date: Sex:

Address: Phone #:

Insurance: Referred by: Occupation:

Instructions: Put ☑ in those boxes applicable to you and in the "YES" or "NO" space. If lines are provided write in your answers.

FAMILY HISTORY

	Father	Mother	Brother 1	Brother 2	Brother 3	Brother 4	Sister 1	Sister 2	Sister 3	Sister 4	Spouse	Children 1	Children 2	Children 3	Children 4	Children 5	Children 6
Age (if living)																	
Health (G) Good (B) Bad																	
Cancer																	
Tuberculosis																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Epilepsy																	
Nervous Breakdown																	
Asthma, Hives, Hay Fever																	
Blood Disease																	
Age (at death)																	
Cause of death																	

PERSONAL HISTORY

Have you ever had…	NO	YES	Have you ever had…	NO	YES	Have you ever had…	NO	YES
☐ Scarlet Fever ☐ Scarlatina			☐ Gonorrhea ☐ Syphilis			Any ☐ Broken ☐ Cracked Bones		
Diptheria			Anemia			Recurrent Dislocations		
Smallpox			Jaundice			☐ Concussion ☐ Head Injury		
Pneumonia			Epilepsy			Ever Been Knocked Unconscious		
Pleurisy			Migraine Headaches			☐ Food ☐ Chemical ☐ Drug Poisoning		
Undulant Fever ☐ Rheumatic Fever			Tuberculosis			Explain:		
Heart Disease			Diabetes					
St. Vitus Dance			Cancer					
☐ Arthritis ☐ Rheumatism			☐ High ☐ Low Blood Pressure			Any Other Disease		
Any ☐ Bone ☐ Joint Disease			Nervous Breakdown			Explain:		
☐ Neuritis ☐ Neuralgia			☐ Hay Fever ☐ Asthma					
☐ Bursitis ☐ Sciatica ☐ Lumbago			☐ Hives ☐ Eczema					
☐ Polio ☐ Menningitis			Frequent ☐ Colds ☐ Sore Throat			Weight: Now One Yr. Ago		
Bright's Disease			Frequent ☐ Infections ☐ Boils			Maximum When		

ALLERGIES

Are you Allergic to …	NO	YES	Are you Allergic to …	NO	YES	Are you Allergic to …	NO	YES
☐ Penicillin ☐ Sulfa Drugs			Any other drugs			Any Foods		
☐ Aspirin ☐ Codeine ☐ Morphine			Explain:			Explain:		
☐ Mycins ☐ Other Antibiotics								
☐ Tetanus ☐ Antitoxin ☐ Serums			Adhesive Tape			☐ Nail Polish ☐ Other Cosmetics		

SURGERY

Have you had Removed…	NO	YES		NO	YES		NO	YES
Tonsils			☐ Ovary ☐ Ovaries			Had Hernia Repaired		
Appendix			Hemorrhoids			Had any other Operations		
Gall Bladder			Ever have a Transfusion			Been Hospitalized for any illness		
Uterus			☐ Blood ☐ Plasma			Explain:		

X-RAYS

Ever have X-Rays of…	NO	YES	Date Disease Present
Chest			
☐ Stomach ☐ Colon			
Gall Bladder			
Extremities			
Back			
Other			

Patient Questionnaire Continued…

SYSTEMS					
Do you now have or have you ever had…	NO	YES	Do you now have or have you ever had…	NO	YES
Any ☐ Eye Disease ☐ Eye Injury ☐ Impaired Sight			Kidney ☐ Disease ☐ Stones		
Any ☐ Ear Disease ☐ Ear Injury ☐ Impaired Hearing			Bladder Disease		
Any Trouble with ☐ Nose ☐ Sinuses ☐ Mouth ☐ Throat			Blood in Urine		
Fainting Spells			☐ Albumin ☐ Sugar ☐ Pus ☐ Etc in Urine		
Convulsions			Difficulty in Urination		
Paralysis			Narrowed Urinary Stream		
Dizziness			Abnormal Thirst		
Headaches ☐ Frequent ☐ Severe			Prostate Trouble		
Enlarged Glands			☐ Stomach Trouble ☐ Ulcer		
Thyroid: ☐ Overactive ☐ Underactive ☐ Enlarged			Indigestion		
Enlarger Goiter			☐ Gas ☐ Belching		
Skin Disease			Appendicitis		
Cough: ☐ Frequent ☐ Chronic			☐ Liver Disease ☐ Gall Bladder Disease		
☐ Chest Pain ☐ Angina Pectoris			☐ Colitis ☐ Other Bowel Disease		
Spitting up Blood			☐ Hemeorrhoids ☐ Rectal Bleeding		
Night Sweats			Black Tarry Stools		
Shortness of Breath ☐ Exertion ☐ At Night			☐ Constipation ☐ Diarrhea		
☐ Palpitation ☐ Fluttering Heart			☐ Parasites ☐ Worms		
Swelling of ☐ Hands ☐ Feet ☐ Ankles			☐ Any change in Appetite ☐ Eating Habits		
Varicose Veins			☐ Any change in Bowel Action ☐ Stools		
Extreme ☐ Tiredness ☐ Weakness			Explain:		

IMMUNIZATION - EKG					
Have you had…	NO	YES	Have you had…	NO	YES
Smallpox Vaccination (Within last 7 years)			Polio Shots (Within last 2 years)		
Tetanus Shot (Not Antitoxin)			An Electrocardiogram When:		

HABITS							
Do you…	NO	YES	Do you use…	Never	Occ	Freq	Daily
Exercise Adequately			Laxatives				
How?			Vitamins				
Awaken Rested			Sedatives				
Sleep Well			Tranquilizers				
Average 8 Hours of Sleep (per night)			Sleeping Pills, Etc				
Have Regular Bowel Movements			Aspirins, Etc				
Sex - Entirely Satisfactory			Cortisone				
Like your work (Hours per day ☐ Indoor ☐ Outdoors			Alcoholic Beverages				
Watch Television (Hours per day)			Coffee (Cups per day)				
Read (Hours per day)			Tobacco: ☐ Cigarettes (Pks per day)				
Have a Vacation (Weeks per year)			☐ Cigars ☐ Pipe ☐ Chewing Tobacco				
Have you ever been treated for Alcoholism?			☐ Snuff				
Have you ever been treated for Drug Abuse?			Appetite Depressants				
Recreation: Do you participate in sports or have hobbies which give you relaxation at least 3 hours a week?			Thyroid Medication ☐ No ☐ Yes, in pas ☐ None Now Have you ever taken.. ☐ Insulin ☐ Tablets for Diabetes ☐ Hormone Shots ☐ Tablets ☐ No				

WOMEN ONLY					
Menstrual History…					
Age at onset			Are you regular: ☐ Heavy ☐ Medium ☐ Light		
Usual Duration of Period Days			Do you have ☐ Tension ☐ Depression before period		
Cycle (Start to Start) Days			Do you have ☐ Cramps ☐ Pain with period		
Date of Last Period			Do you have hot flashes		
Pregnancies…	NO	YES		NO	YES
Children Born Alive (How many)			Still born (How many)		
Cesarean Sections (How many)			Miscarriages (How many)		
Prematures (How many)			Any Complications		

EMOTIONS					
Are you often	NO	YES	Are you often	NO	YES
Depressed			Jumpy		
Anxious			Jittery		
Irritable			Is Concentration Difficult?		

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Patient: DOB:

Problem List

Date of Service	CC – Treatment	Provider

9735 SW Shady Lane, Suite 104
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Dramov Naturopathic Medical Center

This document is a binding agreement (the "Agreement") between DNMC ("We" "Us" "Our") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services which may be provided to You by Us at the present and at all times in the future, You agree as follows (Your agreement indicated by placing Your initials on the lines following each section and Your signature):

1. **Consent For Treatment.** You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You hereby consent to and authorize Us to provide You with health care treatment which, depending on Your health conditions, may include without limitation one or more of the following procedures: naturopathic medicine, dietary, herbal, medical, pharmaceutical and anesthetic treatment, Minor Surgery, Gynecology, Radiofrequency procedures, Acupuncture, Prolotherapy and/or Platelet Rich Plasma injections, Stem Cell injections, Intravenous Micronutrient and Botanical Therapy, (together the "Treatments") administered by Us, our physicians, assistants, consultants and staff. You acknowledge that We have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatments. (Initials)_____

2. **Experimental Nature of Treatment.** You acknowledge and agree that the Treatments may consist in whole or part of experimental procedures and methods, including without limit Acupuncture, Intravenous Micronutrient Therapy, Minor Surgery, Prolotherapy and Platelet Rich Plasma therapy, Stem Cell Therapy, on which no governmental (including the U.S. Food and Drug Administration ("FDA"), scientific or medical authority has confirmed the safety or efficacy thereof. You acknowledge that the safety and efficacy record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe and effective. We have informed You that the Treatments MAY alter, address or decrease Your pain, symptoms or complaints, but also may have no effect. (Initials) _____

3. **Minor Surgery, Prolotherapy, Injection Therapy Risks, Side Effects, Complications.** We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including without limitation swelling; increased pain; bleeding; dizziness, numbness; scarring; scar or keloid formation; asymmetry; allergic reaction; discoloration; soreness, itching, a feeling of "lumpiness" or permanent skin contour irregularities at the site of Treatments], all of which may be permanent. Treatment may very rarely cause infection; injury to nerves, temporary or permanent alteration in sensation; the need for additional surgery or hospitalization; spinal cord injuries, Pneumothorax (temporary lung collapse), paralysis, or other serious or debilitating injuries or death. (Initials)_____

4. **Description of Treatments.** The exact procedure, as well as the recommended sequence of Treatments, will be explained to You when We actually administer the Treatments. You acknowledge that any of the Treatments may involve insertion of needles into Your skin and veins and the injection of standardized formulas which may include various nutritional substances, hormones, homeopathic medicines, and FDA approved prescriptive medicines, chelating agents, local anesthetic (procaine, Ropivacaine, Lidocaine), concentrated sugar water or dextrose, concentrates or your own blood (platelet Rich Plasma, Bone Marrow Stem Cells, Fat Derived Stem Cells) and, on occasion, other substances and local subcutaneous anesthetic infiltration (with or without epinephrine) which will be explained to you before injections. (Initials)_____

5. **Medical Staff.** You are aware that among those who attend You on Our behalf are medical, nursing and other health care personnel employed by Us or in training, who unless requested otherwise, may participate in Your patient care. (Initials)_____

6. **Information You Provide Us.** You have provided Us with a complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medicines, dietary supplements or medical treatments of any kind. You agree to update this list per changes. (Initials)_____

7. **Assumption of Risk.** You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any questions about this Agreement or the Treatments that You have, You are willing to assume any and all risks associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may/or could arise from the Treatments, but that by initialing and signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed. (Initials)_____

8. **Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action. (Initials)_____

9. **Miscellaneous.** You agree that this Agreement constitutes the entire agreement between You and Us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by You. This Agreement shall be binding on You and Your successors, heirs, legal representatives and assigns. In case anyone of the provisions of this Agreement is held invalid or illegal, such provision shall be curtailed, limited or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the State of Oregon without regard to any choice of law principal. Any dispute between You and Us shall be adjudicated in state or federal court in Washington County, Oregon, and You submit to the jurisdiction of any such court. (Initials)_____

BY SIGNING THIS AGREEMENT, YOU INDICATE THAT YOU HAVE READ, UNDERSTAND AND AGREE TO ITS TERMS, YOU HAVE RECEIVED A COPY OF THIS AGREEMENT, AND THAT YOU ARE THE PATIENT, GUARANTOR, THE PATIENT'S LEGAL REPRESENTATIVE OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS

Print Patient Name _____ Legal Guardian _____

Signature _____Date _____ Signature _____Date _____

Physician Certification: I nearby certify that one of my associates or I have explained to the patient or authorized person the nature of the proposed treatments, the medically significant alternatives, and in lay terms the purpose, likelihood of success, benefits, and reasonably foreseeable risks, complications, and consequences of treatment. The patient or person authorized has had the opportunity to ask questions and has stated that no further explanation was desired.

Representative Signature (DNMC)_____Date_____

Dramov Naturopathic Medical Center

FINANCIAL POLICIES and OTHER FEES

Please take time to read and sign this financial responsibility statement before your first visit.

PAYMENT POLICY:
All account balances are due at the time of service. Prepayment is required to secure a scheduled new patient appointment. We reserve the right to not extend credit, as this is not a service we guarantee. We accept cash, checks, and credit cards.

INSURANCE POLICY:
Dr. Rob Dramov is a preferred provider for some insurance companies. We do not offer billing services for other insurance companies. If requested, we will provide you with the proper paperwork to submit on your own for reimbursement. You are responsible to know your coverage, you are responsible for in house pharmacy and services not covered by your insurance or services you choose to pay directly at time of service pay basis.

Please confirm your insurance coverage with the front desk staff before coming in for your first appointment. Due to the variability of insurance coverage in general and for Naturopathic coverage in particular, we strongly suggest you call your insurance provider to determine which services might be covered in your policy, and to what extent. For the insurance company we do bill for, all co-pays, deductible amounts and uncovered service charges are due at the time of service.

INTEREST FEES: There is no interest or finance charge on current accounts. After 45 days, all accounts are subject to a monthly finance charge of 2.0% of the unpaid balance, which is an annual percentage rate of 24% (or a minimum charge of $1.00).

MISSED / LATE CANCELLATION APPOINTMENT FEES:
The fee for the missed appointment is based on the services that were scheduled. One full working day is required to change or cancel return visits for established patients. We may charge for missed return appointments, or appointments not canceled or rescheduled within the time frame stated above.

EMAIL AND PHONE CONSULTS:
There are times when consults will be held over the phone or via email. There are fees for those services and you are responsible for those as we do not bill those to insurance.

ACKNOWLEDGMENT:
I have read this financial policy statement and understand its terms. I understand prices and policies are subject to change. I understand that delinquent accounts may be assigned to a credit reporting collections service. If it becomes necessary to pursue collections of any amount owed, I agree to pay for all costs and expenses, including reasonable attorney fees. There will be a fee added to any accounts referred to collections. I hereby authorize the DNMC to release any information necessary to secure payment.

Print Patient's Name: _____

Responsible Party:_____ Relationship to patient: _____

Signature of responsible party:_____ Date: _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to this information. Please review it carefully.

Protected Health Information (PHI) is defined as any information whether oral or recorded, in any form or medium that is created or received by a healthcare provider that connects the patient's name to any treatment, financial status or health status in the past, present or future. PHI is generally used when we send and receive information to / from doctors, lawyers, pharmacies and insurance companies.

If PHI is requested by another office or by the patient, we request the patient sign a release form before any information can be shared or released. There is an understanding that we may send PHI if requested by your insurance company in order to secure payment for you or DNMC. Only the minimum information necessary will be shared, as a rule.

Disclosure of PHI in the following cases do not require patient consent: If the disclosure is required by law, if the request is from the public health authority, if the request involves child abuse, neglect, domestic violence, in judicial and administrative proceedings, requests from law enforcement, requests for cadaver organ, eye or tissue donation purposes, food and drug administration requests, in cases of communicable diseases, to avert a serious and imminent threat to health and safety, or workers compensation.

Patients have the right to receive a copy of this Notice of Privacy Practices. They have the right to access their own PHI and to request amendments and restrictions. Patients have the right to not be intimidated or threatened when making these requests. We may not require them to sign a waiver, relinquishing these rights, in order to receive treatment. Patient's names will not be used in any fundraising or venture without prior authorization, except for our mailing list. Patients can be removed from this list by request.

Unless we are otherwise directed, PHI will only be released to friends and / or family if the patient is incapacitated or it is an emergency and ONLY if the doctor decides that the is in the best interests of the patient. If you have family members who you would like to authorize access to your PHI, please add their name(s) to the bottom of this form. Custodial parents have access to their children's PHI if they are minors unless another agreement has been made or the doctor believes there is a possibility of child abuse / neglect.

If a patient requests an amendment of, or access to their PHI, depending on the situation, the doctor may or may not comply. If access or amendments are denied, the patient will be provided with a statement that includes the reasons for that denial. Our office has 30 days to respond to any request for information. If the requested information is kept off-site, our office has 60 days to respond. If the patient does not agree with the doctor's decision, there is an appeals process that will be explained to the patient at that time.

Our staff are trained in privacy and security procedures. The front staff members have limited access to all active patient files and also to existing archived files for DNMC. The office routinely destroys files after 10 years of inactivity. They do not have authority to review and / or release test results, or to access any PHI without appropriate reasons. The practitioners in the office have access to their patients' PHI only, unless the on call doctor needs to access the PHI to assist the patient.
I have read the above notice.

Signature: _____ Date_____ Print name: _____

I would like a copy of this notice: Yes/No

I authorize DNMC to share my PHI with: _____Relationship_____

We have a copy of our complete Privacy Policy available upon request.