Natural Health Clinic 5500 Madison Ave., Suite A, Sacramento, CA 95841
(916)349-9223 fax (916)332-3429

Please Print legibly

Name _____ Home Phone (____) ____-_____

Work Phone (____) ____-_____ Other phone (____) ____-_____ SS # _____-_____-_____

Address _____ City _____ State ____ Zip _____

Patient Date of Birth: ____/____/_____ Age _____ Height _____ Weight _____ Sex M F

*** Fill out for patient unless patient is a child. Then fill out for parent.**

Employer _____ Occupation _____

Address _____ City, State, Zip _____

Emergency Contact _____ relationship _____ phone (____) _____-_____

Email _____ Drivers license # _____

Marital Status M S D W # of children Boys _____ Girls _____ Spouses Name _____

How were you referred to our office? _____

Person Financially Responsible (when paying cash, disregard insurance info)

Medical Insurance **Y N** Name of Insured _____ Relationship to patient _____

Insurance company _____ ID # _____ Group # _____

Ins. Phone (____) _____-_____ Claims Address _____

SS# of insured _____-_____-_____

Payment is due at the time of service

Assignment of Insurance Payments

I hereby assign all medical and/or surgical benefits to which I am entitled, including Major Medical, Medicare, private insurance or any other health plans to Dr. Roc Gantt. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: _____ Date: ____/____/_____

Consent to treatment

I, _____ hereby consent, authorize and request Dr. Roc H. Gantt, OMD, Lac to administer the treatment deemed advisable and necessary to my condition in accordance with his best expertise. I agree to hold him free and harmless from any claims, suits for damages or complications that may result from such treatment.

Signed _____ Date ___/___/_____

Family History

Father (age) _____ Living ___ Mother (age) _____ Living ___ Brothers _____ Sisters _____

___ Diabetes ___ Asthma ___ Cancer ___ Mental Disease
___ Heart Disease ___ Lung Disease ___ Arthritis ___ Allergies
Other or details _____

Personal History:

Childhood diseases: ___ Measles ___ Mumps ___ Chicken Pox
Unusual childhood illnesses _____

Do you smoke? **Y N** How many _____ Do you drink coffee? **Y N** How much _____

Do you take drugs? **Y N** List names _____

Do you take vitamins? **Y N** List names _____

Do you exercise? ___ Regularly ___ Infrequently ___ Seldom Do you have a pacemaker? **Y N**

Hobbies _____

Past History:

List significant injuries (slips, falls, auto accidents, etc.) with approximate dates.

Have you had previous back trouble? **Y N** Please provide dates and details _____

List past significant illnesses _____

List All operations with dates _____

Current Medications**: Y N** _____

List known allergies _____

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Have you seen any chiropractor before? **Y N** Name & address _____

Last Adjustment ____/____/_____ Last Physical ____/____/_____ Findings _____

Have you had x-rays in the past 2 years? **Y N** Where _____ what body part _____

If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of day or night you experience these symptoms, indicating whether they occur daily, occasionally, etc.

_____
_____
_____
_____

Would you say you are under a lot of stress? **Y N** explain _____
_____

Do you experience?

___Undue worry ___Difficulty concentrating ___ Forgetfulness ___Memory problems

Females: Do you experience any pain or discomfort before, during or after menstrual cycle? Do you experience any discomforts during the cycle week? (regardless of whether you menstruate, are in menopause or have had surgical removal of all or part of the female reproductive organs or skip your periods periodically) During the week are you "grouchy"? Irritable? Have crying spells, feel uptight, more nervous, or specify any other problems.
Describe: _____
_____

Check the symptoms you experience:

___ Headaches	___ Blurred vision	___ Dizziness	___ Labored breathing
___ Morning fatigue	___ General fatigue	___ Indigestion	___ Shortness of Breath
___ Heartburn	___ Lump in throat	___ Numbness	___ Throat constriction
___ Fainting spells	___ Light headedness	___ Joint swelling	___ excessive perspiration
___ Excessive gas	___ Constipation	___ Loose stools	___ Palpitation of the heart
___ Insomnia	___ Hot flashes	___ Poor memory	___ Poor Excessive appetite
___ Sexual impotency	___ Dry skin	___ Night sweats	___ Nerves

___ Other _____

Chief complaint: _____
_____

Describe present complaint fully: _____

Duration of present condition: _____

What do you believe caused this condition? _____

New Patient Intake Form

Is your condition due to an accident or illness? **Y N** Auto accident? **Y N** Work place injury? **Y N**

When were you last seen by a healthcare provider? ___/___/____ who? _____

Who is your Doctor? _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone ____-____-_____ Diagnosis _____

List all foods and beverages taken more than 3 times a week. _____

_____

_____

_____

Additional important information: _____

To be completed by Doctor

Temp: _____ Pulse: _____ Respiration: _____

Blood pressure Lying: _____ Standing: _____

General appearance: _____

Lab work: _____

Diagnosis: _____

Treatment plan: _____

_____

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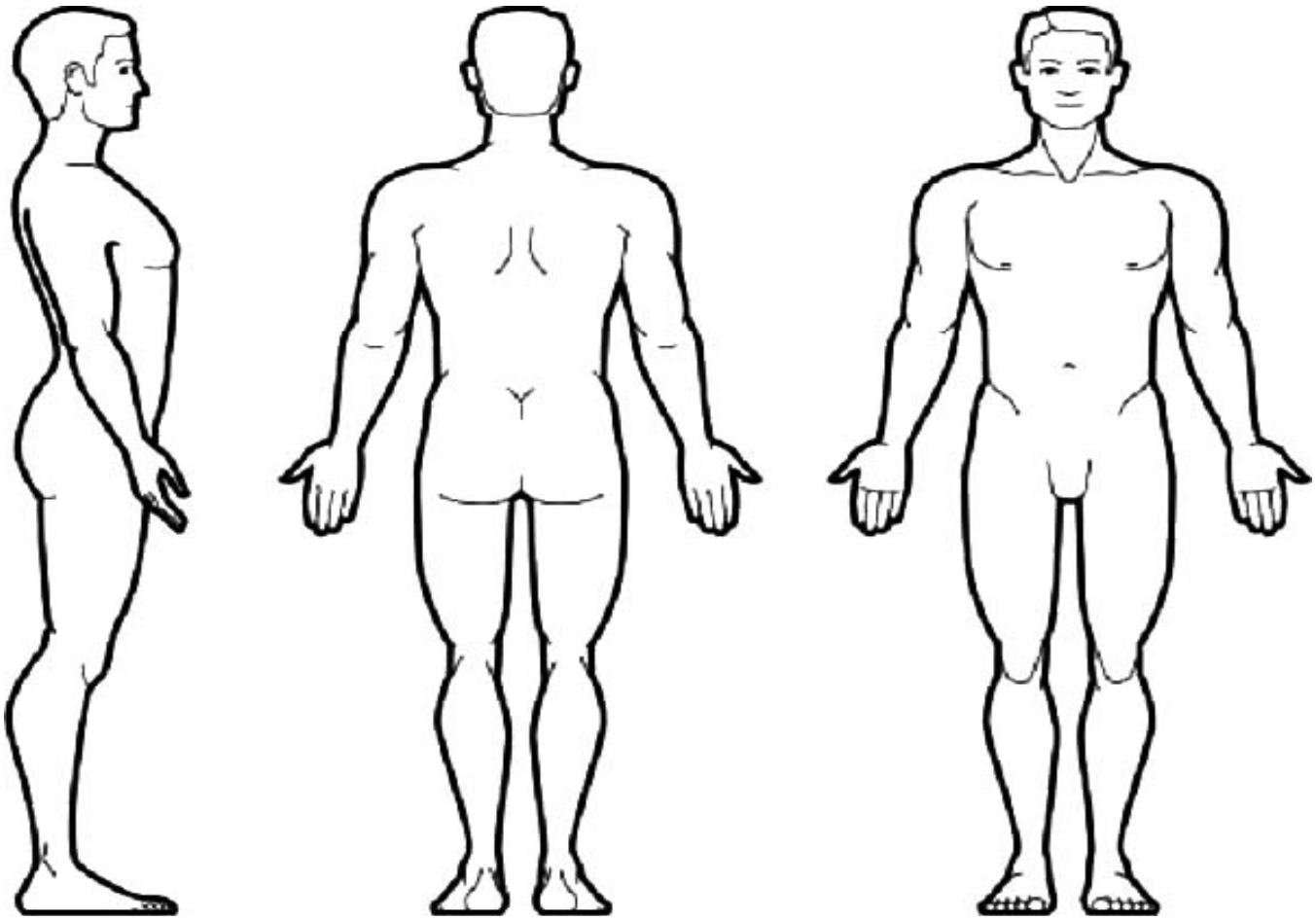
Show me where it hurts

Pain Scale: Select the appropriate pain number and place it where it hurts you.

No Pain Minimal Slight Moderate Severe Pain

0 1 2 3 4 5 6 7 8 9 10



My Pain is: ( ) Constant ( ) Frequent ( ) Intermittent ( ) Occasional

I am also suffering from :

( ) Stress ( ) Tension ( ) Depression
( ) I have sleep trouble ( ) I have no energy ( ) I am moody

( ) Much Improvement ( ) Some Improvement ( ) No Improvement ( ) Worse

Patient Signature _____ Date ___/____/_____

Informed Consent

Patient's request for Acupuncture and/ or Physiotherapy Care

Dear Patient:

We would like to personally welcome you to our clinic. This notice is to advise you that every type of healthcare delivery system, including acupuncture, has some risks and the potential for occasional problems of some kind. These problems can include temporary soreness, sprain/strain, bruising, burns, stroke, etc. In considering these issues, remember that each person's problems, injuries and/ or complaints are unique, and treatment that might be very effective for one person might not be as effective for another person. While we are committed to providing you with the best and safest treatment possible, we also have a legal responsibility to advise you about some very rare but potential problems that can occur with acupuncture care and/ or physiotherapy. Before you start your treatment with us, you need to review this information, which is called your "informed Consent". Please feel free to discuss any questions or concerns that you may have directly with us before you start any of your treatments at our clinic. Remember that we are always have time to talk to you about any concerns and/ or questions.

Patient Signature _____ Date ____/____/_____

Legal Guardian Signature _____ Date ____/____/_____

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2017 Patient Payment Schedule

(Subject to change without notification)

Initial Visit/ Consultation	$105
Acupuncture	$ 75
Prepay Acupuncture (10 visits)	$600
NAET / AACT (Nambudripad Allergy Elimination Technique)	$ 75
Prepay (NAET – AACT) (10 visits)	$600
NRT (Nutritional Response Testing)	$ 45
Prepay (NRT) (10 Visits)	$350
HRV (Heart Rate Variability Test)	$ 45
Ion Spa Detox Footbath	$ 35
Prepay Ion Spa Detox Footbath (10 visits)	$300

(There is no refund on prepays. Any amount left can be used by/ given to another member of your family, friend or other designate to use remaining treatment(s))

Phone Consultation	$ 50
Missed Appointment	$ 35
House Call	$120
Returned Checks	$ 25

(Insurance rates differ and are billed by medical procedure codes)

Thank you for your business.

Signed _____ Date ____/____/_____

Clinic Cancellation Policy

Scheduled appointment times are reserved for you only, and can be made at your convenience It is important and highly beneficial for you to make all appointments so as to ensure your optimal health. That is why we do our best to have convenient appointment times available, as well as to offer same day scheduling for your convenience. Your comfort is important to us and we will do our best to make scheduling appointments an easy experience. We also understand that some things may come up that may prevent you from attending your appointment, and for this reason we allow rescheduling up to 24 hours prior to your scheduled time without consequence. Because of our concern for comfort to you as well as the rest of our patients, it is important that we do receive at least 24 hours notice if you must reschedule an appointment. Without such notice, a cancellation/ missed appointment fee of $35 must be assessed. This is how we are able to offer same-day scheduling to keep the scheduling process as simple and convenient as possible.

We sincerely appreciate your cooperation in the practice of our policy and hope it helps you to keep appointment scheduling a convenient process for each and every one of our patients.

I have read and understand the above policy and agree to pay any fees assessed with my missed or cancelled appointment without 24 hours notice.

Signed _____ Date ____/____/_____

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Consent to Treat a Minor

I (We) being the parent(s) or guardian(s) of _____, a minor, the age of _____ do here by consent, authorize and request Dr. Roc H. Gantt, O.M.D., Lac., to administer such treatment deemed advisable, necessary or requested on the above minor.

I (We) agree to hold him free and harmless from any claims, suits for damages, or, complications that may result from such treatment.

Parent/ Guardian signature _____

Parent/ Guardian signature _____

Witness signature _____