Kimberley A. Schroeder, D.O.
115 Baker Drive, Tomball, TX 77375
(281) 290-0531 www.feelwellagain.com

PATIENT DEMOGRAPHICS

LEGAL NAME: _____
FIRST MIDDLE LAST

DOB: SEX: MALE / FEMALE RACE:

MAILING ADDRESS: _____

CITY/ST: ZIP:

MARITAL STATUS: OCCUPATION:

HOME PHONE: CELL PHONE:

WORK PHONE: EXT:

MAY WE LEAVE A DETAILED MESSAGE ON YOUR HOME PHONE? CELL PHONE?

E-MAIL: _____

*E-MAIL NOTIFICATION: We do not give out your e-mail address to anyone.

WE SEND OFFICE REMINDERS BY TEXT. IF YOU PREFER NOT TO RECEIVE TEXT REMINDERS, CHECK HERE _____

EMERGENCY CONTACT: _____

PHONE: RELATIONSHIP:

PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

Institute for Health and Wellness

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Thank you for allowing our office the privilege of serving your medical needs. The Institute for Health and Wellness is a place where the genuine care and welfare of our patients is our highest mission.

TREATMENT DISCLOSURE

- As a patient at the Institute for Health and Wellness, I am seeking complementary and/or an alternative approach for the treatment of my health concerns/issues.
- I have chosen to come to the Institute for Health and Wellness because the conventional method of treatment is unacceptable as a sole method of treatment.

INSURANCE CONSIDERATION

- I understand that my insurance is a contract between me, my employer, and the insurance company and that that the Institute for Health and Wellness is not a party to that contract.
- I understand that I am ultimately responsible for all charges incurred for all services rendered.
- I understand that I am responsible for submitting claims to my insurance for possible reimbursement.
- I understand that it is rare for insurance companies to cover the services I receive at the Institute for Health and Wellness because they are based upon a natural and preventative approach.
- I understand that the Institute for Health and Wellness is unable to provide any additional assistance in regards to claims beyond submitting medical records.
- I authorize the Institute for Health & Wellness to send my complete medical record to my insurance company if they are requested.

MEDICARE WAIVER

- I understand that the Institute for Health and Wellness is not a Medicare, Medicaid, Champus, WPS or TriCare Provider and has chosen to Opt Out of Medicare.
- I accept full financial responsibility for any charges incurred.
- I understand that by signing this form, I waive my rights to seek reimbursement from Medicare, Medicaid, Champus, WPS or TriCare or file any claims to Medicare, Medicaid, Champus, WPS or TriCare for these services.
- I understand that I am unable to file to Medicare, Medicaid, Champus, WPS or TriCare even if it is merely to get a denial in order to file with any other insurance policies.

I, (Print Name)_____, *certify by my signature that I have read and agree to the terms of all of the above.*

PATIENT OR RESPONSIBLE PARTY SIGNATURE DOB DATE

A PHOTOCOPY OR ELECTRONIC SCAN OF THIS DOCUMENT SHALL BE AS EFFECTIVE AND VALID AS THE ORIGINAL.

PAST MEDICAL HISTORY

NAME: DATE OF BIRTH:

MAJOR EVENTS / HOSPITALIZATIONS / SURGERIES: DATES:

1 _____ _____

2 _____ _____

3 _____ _____

4 _____ _____

5 _____ _____

ALLERGIES:

ONGOING MEDICAL PROBLEMS:

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

FAMILY MEDICAL HISTORY:

MOTHER: _____

FATHER: _____

BROTHER(S): _____

SISTER(S): _____

GRANDPARENT(S): _____

PREVENTATIVE - TO THE BEST OF YOUR KNOWLEDGE WHEN WAS YOUR LAST: BONE DENSITY _____

MAMMOGRAM _____ PAP SMEAR _____ PROSTATE EXAM _____

NUTRITION HISTORY - SPECIAL DIETARY PREFERENCES/NEEDS: (VEGAN, VEGETARIAN, GLUCOSE-INTOLERANT, ETC.)

REFERRED BY: _____

NAME: DATE OF BIRTH:

☐ I am not taking any medications at this time.

Medication Name	Strength	Dosage	Length of time taken
1			
2			
3			
4			
5			
6			
7			
8			
9			

☐ I am not taking any supplements at this time.

Supplement Brand/Name	Strength	Dosage	Length of time taken
1			
2			
3			
4			
5			
6			
7			
8			
9			

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INFORMATION RELEASE

PATIENT NAME: DATE OF BIRTH:

I authorize Dr. Schroeder and her staff to leave detailed, confidential medical information on the following phone number's voicemail at any time and for any reason:

Phone Number_____

I authorize Dr. Schroeder and her staff to discuss my confidential medical information with the following people at any time and for any reason:

Name of person_____

I authorize Dr. Schroeder and her staff to send my lab results upon my verbal request to the following: **(Fax Number or Mailing Address ONLY)**

Fax #_____Mailing Address_____

_____ ***Initial*** I understand that if I would like any other portion of my medical record sent to me Texas law requires me to complete a release form which is available upon request from Dr. Schroeder's office.

_____ ***Initial*** I understand that the information disclosed under this authorization may be disclosed again by the above authorized person(s). The privacy of this information may not be protected under the federal privacy regulations.

_____ ***Initial*** I understand that communication with Dr. Schroeder and her staff via e-mail, Facebook or personal cell phones is not encrypted and therefore not recommended due to privacy concerns.

This authorization remains in effect unless amended or terminated in writing to our office by the patient or patient's authorized representative.

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE

PRINT NAME OF LEGALLY AUTHORIZED REPRESENTATIVE RELATIONSHIP TO PATIENT