Dr. Dawn Lamb

815 2nd Ave Suite 205
Fairbanks, Alaska 99701
Office - 907-328-0880
Fax - 907-328-0889

Client Information

Today's Date _____

Client's Name:_____**DOB:**_____**SSN:**_____-_____-_____

Marital Status: Single Married Divorced Widowed Separated Unknown

Mailing Address:_____

Home Phone (_____)_____**Work Phone: (_____)**_____ **Cell Phone: (_____)**_____

Spouse Information

Spouse's Name: _____ **DOB:** _____ **SSN:** _____-_____-_____

Mailing Address:_____

Home Phone (_____)_____**Work Phone: (_____)**_____ **Cell Phone: (_____)**_____

Is Patient a MINOR? YES NO

Parent/Legal Guardian of minor _____
(Person responsible for bill if patient is under 18)

Mailing Address: _____

Home Phone (_____) _____**Work Phone: (_____)**_____ **Cell Phone: (_____)**_____

Responsible Party Employment Contact Info: _____

Emergency Contact Information

Contact: _____ **Phone: (_____)**_____ **Relationship:**_____

Who can we thank for referring you today? _____
(How did you hear about us?)

IS YOUR PRIMARY INSURANCE MEDICARE? YES NO

Primary Insurance Information (NOT MEDICARE)

Name of Insurance Company: _____ **Policy or ID#:** _____

Policy Holder Name: _____ **DOB:**_____ **SSN:** _____-_____-_____

Policy Holders Employer: _____ **Policy Holder's Work Phone:** _____

Patient Relationship to Policy Holder: Self Spouse Dependent Other: _____

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Employment Information

Employment Status: None FT PT Self-Emp. Retired Student

Employer Name: _____ Employer Phone: (_____)_____

PAST MEDICAL HISTORY FORM

Circle all which apply to you

Diabetes	Yes	No
Allergies	Yes	No
Chest Pain / Angina	Yes	No
High Blood Pressure	Yes	No
Heart Disease	Yes	No
Osteoporosis	Yes	No
Thyroid problems	Yes	No
Hernia	Yes	No
Heart Palpitations	Yes	No
Seizures	Yes	No
Headaches Dizziness / Fainting	Yes	No
Kidney Problems	Yes	No
High Cholesterol	Yes	No
Are you or could you be pregnant?	Yes	No
Surgeries	Yes	No
Cancer	Yes	No
Skin Abnormalities	Yes	No
Bowel / Bladder Abnormalities	Yes	No
Nausea / Vomiting	Yes	No
Smoking	Yes	No
Ringing in your ears	Yes	No
Asthma / Breathing Difficulties	Yes	No
Arthritis	Yes	No
Liver / Gallbladder Problems	Yes	No
Special Diet Guidelines	Yes	No
Stroke/CVA	Yes	No

Other:_____

Is there any other information regarding your past medical history that we should know about?

_____

_____

Are you presently taking Medication or Supplements? Yes No

If yes, please list what medications and for what condition:

_____

_____

Authorization: I understand full payment for treatment received is my responsibility regardless of my insurance coverage. I hereby authorize the clinic of Dr. Dawn Lamb to release to my insurance company any information acquired in the course of examination or treatment. I further authorize my insurance company to pay directly to Dr. Dawn Lamb and Medical benefits due to me that have not been paid. This authorization shall expire upon written notice or one year from this date.

SIGNATURE _____ **Date:** _____

CLIENT PAYMENT AGREEMENT

$ **I have been informed by Dr. Lamb that some insurance companies do not cover alternative/naturopathic treatments and I understand that I am responsible for any charges NOT COVERED AND PAID by my insurance company._____ (initials guarantor)**

$ **ASSIGNMENT OF INSURANCE/BENEFITS: By signing below, I authorize Natural Health Options to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. This authorization shall be valid only for the period of time necessary to actually process payment claim pertaining to the client.**

$ **Dr. Lamb does not carry medical malpractice insurance.**

$ **I have been informed that Dr. Lamb adheres to HIPAA mandated privacy and confidentiality practices. _____ (initials guarantor)**

$ **THIS PRACTICE IS NOT ENROLLED IN FEDERAL OR STATE PROGRAMS, AND THEREFORE DOES NOT ACCEPT ASSIGNMENT OF BENEFITS FOR FINANCIAL PROGRAMS OF THIS NATURE.**

$ **Dr Lamb and her Clinic do not file Secondary Insurances. The front office staff will be happy to give you the appropriate form(s) to do so yourself.**

Cancellation Policy

There is a fee charged for appointments not cancelled 24 hours prior to the scheduled appointment which is billed at the amount of one (1) hour of service. Insurance companies WILL NOT be billed this amount. It will solely be the patients responsibility.

SIGNATURE:_____DATE:_____

WITNESS:_____DATE:_____

(Office use)