NEW PATIENT REGISTRATION

Today's date:	Your Primary Care Practitioner/Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle Initial:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐M ☐F

Street address:				Home phone : ( )
City:	State:	ZIP Code:	Email:	Cell phone : ( )
Occupation:	Employer:			Employer phone: ( )

Were you referred to our Office? ☐ Yes ☐No If yes, by whom?

(*Mark all that apply*) **You may leave voice mail *appointment reminders* at:** *Home:* ☐ *Work:* ☐ *Cell:* ☐ *Text:* ☐

You may send *general information* and *appointment reminders* by Email or Text Message noted above: ☐	**You may share *general information* with the following person:** (relationship)

Name of Spouse/Parent: Phone:

Occupation: Work Phone:

Employer:

Date Of Last Exam:

Are you taking any medication - prescription or over the counter: Y N - if yes please list:

WOMEN ONLY: To Your Knowledge, ARE YOU PREGNANT? Y N Were past pregnancies, if any, normal? Y N

Are you seeing an OBGYN regularly? Y N Physician _____ Phone: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Cell phone: ( )

1. I understand that I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefit program does not pay.
2. I authorize my insurer, health plan, employer program or similar benefit program to release information to you regarding my coverage.
3. My right to payment for care, treatment, supplies and other services are hereby assigned to you. This assignment covers any and all benefits under Medicare, other government sponsored programs, insurance, employer programs and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. If my insurer, health plan, employer program or similar benefit program does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to you.
4. I understand and **authorize release** of all health information about me to my insurer, health plan, employer program or similar benefit program identified above **to obtain payment** for care, treatment, supplies and other services. The above information is true to the best of my knowledge.

Patient/Guardian signature *Date*

Fill out reverse side >

For Office Use Only (Rev. 1.0)

Date Received: _____ File Reference #: _____ Action: _____

Person Acting: _____ ☐ Response/ Date: _____ ☐ Filed Without Response

FAMILY HISTORY (Please check all that apply)

	Cancer	Diabetes	Heart Trouble	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problems	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Diseases	Other	Deceased
Father																		
Mother																		
Brother(s)																		
Sister(s)																		
Children																		
Aunt/Uncle																		

ACTIVITIES/HABITS (Please check proper box)	**Never**	**< 1**	**1-2**	**2-3**	**3-4**	**5+**
Smoking (packs per day						
Caffeinated Drinks (cups per day)						
Alcohol Consumption (drinks per day)						
Exercise (Days per week)						
What type of exercise do you do?						
Drug/Substance Abuse? YES NO If YES, discuss with Doctor						

Your GOAL for care?

CONSENT FORM AND DISCLAIMER

NUTITIONAL THERAPY

The absence of a warning for a given drug or supplement or any combination thereof in no way should be construed to indicate that the drug or supplement or any combination thereof is safe, effective, or appropriate for you. Statements made about a supplement, product or treatment have not been evaluated by the Food and Drug Administration (FDA) and any mentioned supplement, product or treatment is not intended to diagnose, treat, cure, or prevent any disease.

Nutritional therapy is designed to improve your health but is not designed to treat any specific disease or medical condition.

If you are using medications, you need to inform Dr. Moore of their use, as well as discuss potential interactions between medications and nutritional products with your pharmacist.

If you have any physical or emotional reaction to the nutritional products, discontinue use and contact Dr. Moore to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the therapy.

COLD LASER/LOW LEVEL LASER

The lasers are ***not*** to be viewed directly. The potential risk of eye injury may occur, as with any bright light, if you stare directly into the laser light beam. There are no other known side effects that have been observed in previous clinical studies, however, an occasional temporary redness or tingling may accompany the treatment at the site of treatment. This effect normally disappears soon after treatment. A possibility also exists that unknown adverse effects may occur, which is true with any new medical procedure or investigational device.

EB 305/ENERGY BALANCE/DETOX

Do Not Use if you have a pacemaker, organ transplant, arrhythmia or are taking heart regulating medications.

Do Not Use if you have open wounds on your feet.

Do Not Use if you are pregnant or lactating.

Do Not Use if you are on medications related to psychotic episodes or seizures.

Diabetics or patients with low blood sugar should eat a meal prior to treatment. It is recommended to add trace minerals and replenish fluids to balance the body after each treatment.

Because your insurance coverage will not cover these services and treatments, payment is due at time of service. Please understand that even though your insurance company does not cover these services or treatments, they are not to be considered as ineffective or irrelevant.

Any recommendation is not meant to diagnose, treat or cure a disease nor is it intended to replace the advice of your medical practitioner. Rather, it is supportive in helping you return to health and vitality.

Patient Signature: _____ **Date:** _____

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

To be respectful of the medical needs of other patients, please be courteous and call promptly if you are unable to show up for an appointment. This time will be reallocated to someone who needs treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call 253-858-9880. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and schedule you the next available appointment time.
Late Cancellations:

A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

- **First missed** appointment: there will be no charge
- **Second missed** appointment: **$35** fee will be billed to your account
- **Third missed** appointment: **$60** fee will be billed to your account and you may be discharged from our practice

Patient Signature: _____