**Date of First Office Call:** _____


# Dr. Gretchen Imdieke, ND

NATUROPATHIC FAMILY MEDICINE

4270 Kilauea Rd Kilauea, HI 96754 p: 808-652-6407


## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Last Name | | Date of Birth | |
| Legal 1st Name | | Sex | |
| Middle Name | | Marital Status | |
| Mail Address | | Occupation | |
| City | | Name of Spouse or Partner | |
| State | | Names of Children (if any) | |
| Zip | | | |
| Home Phone | | | |
| Cell Phone | | | |

## PRIMARY INSURANCE (Please present your insurance card at first visit)

Name of Insurance (Insurance Company) _____

Type of Plan (HMO, PPO, Medicaid) _____

Policy/Group Number: _____

ID/Subscriber Number: _____

Person Insured if not yourself: _____

## ASSOCIATIONS

Employer or School if student _____

Primary Care Provider (physician) _____

How were you referred to us?
- ☐ Physician (name):
- ☐ Patient (name):
- ☐ Website
- ☐ Other

Please give us information to thank your referral source:

## CUSTOM FIELDS

Secure Message Phone (check One): ☐ Cell Phone ☐ Home Phone

Your E-mail address: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____

**Patient Name:** _____ **Date of First Office Call:** _____

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## REASON FOR VISIT

Please list your present health concerns, problems or symptoms:

## PATIENT INFORMATION

When was your last: Physical exam: _____ Blood work: _____

Physician's name: _____ Phone #: _____

| | Yes | No |
|---|---|---|
| **1.** Are you currently under medical treatment? | ☐ | ☐ |
| *Please describe:* _____ | | |
| **2.** Have you had any serious illnesses or operations? | ☐ | ☐ |
| *Please describe:* _____ | | |
| **3.** Women only | | |
| Do you have regular periods? | ☐ | ☐ |
| Are you taking birth control? | ☐ | ☐ |
| Have you ever been pregnant? | ☐ | ☐ |
| Number of Pregnancies:_____ | | |

| | Yes | No |
|---|---|---|
| **4.** Are you currently taking any medications including over the counter medications? | ☐ | ☐ |
| *Please describe:* _____ | | |
| **5.** Have you ever had a reaction to: | Yes | No |
| Local anesthetics (eg. Novocaine)…… | ☐ | ☐ |
| Penicillin or other antibiotics…… | ☐ | ☐ |
| Barbiturates (sleeping pills) | ☐ | ☐ |
| Sedatives……... | ☐ | ☐ |
| Iodine…… | ☐ | ☐ |
| Aspirin…….. | ☐ | ☐ |
| Other…… | ☐ | ☐ |

| **Have you ever had :** | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Anemia | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Polio | ☐ | ☐ |
| Anorexia | ☐ | ☐ | Heart Disease | ☐ | ☐ | Prostate Problem | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Hepatitis-Type_____ | ☐ | ☐ | Psychiatric Care | ☐ | ☐ |
| Asthma | ☐ | ☐ | Hernia | ☐ | ☐ | Respiratory Disease | ☐ | ☐ |
| Back Problems | ☐ | ☐ | Herpes | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Bleeding Tendency | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Shortness of Breath | ☐ | ☐ |
| Blood Disease | ☐ | ☐ | HIV/AIDS | ☐ | ☐ | Sinus Trouble | ☐ | ☐ |
| Cancer | ☐ | ☐ | Jaundice | ☐ | ☐ | Skin Rash | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Stroke | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | Latex Sensitivity | ☐ | ☐ | Thyroid Problems | ☐ | ☐ |
| Chicken Pox | ☐ | ☐ | Liver Disease | ☐ | ☐ | Tonsillitis | ☐ | ☐ |
| Chronic Fatigue syndrome | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Circulatory Problems | ☐ | ☐ | Measles | ☐ | ☐ | Ulcer | ☐ | ☐ |
| Congenital Heart Lesions | ☐ | ☐ | Migraine Headaches | ☐ | ☐ | Venereal Disease | ☐ | ☐ |
| Cough-persistent or bloody | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Any other condition | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Mumps | ☐ | ☐ | Please describe: | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Multiple Sclerosis | ☐ | ☐ | | | |
| Epilepsy | ☐ | ☐ | Pacemaker | ☐ | ☐ | | | |
| Glaucoma | ☐ | ☐ | Pneumonia | ☐ | ☐ | | | |

## ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Gretchen Imdieke ND, LLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or the behalf of my dependants. I authorize Gretchen Imdieke ND, LLC to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize Gretchen Imdieke, ND to leave personal medical information for me on the secure phone number, which I have indicated on this form.

**Signature of Responsible Party**_____ **Date**_____