Nurturing Optimal Wellness

Nancy Russell, MD

5140 N. Antioch, Kansas City, MO 64119-2523

(816) 453-5545

PATIENT INFORMATION

Name: _____ Name you prefer to be called: _____
(Last) (First) (Middle)
Birth Date: ____/____/_____ SS# _____-_____-_____ Sex: _____ Marital Status: _____
Street Address: _____ Apt#: _____ Home Phone: (____) _____
City: _____ State: _____ Zip: _____ Cell Phone: (____) _____
Employer: _____ Work Phone: (____) _____ Ext: _____
Spouse's Name: _____ E-mail Address: _____

PERSON RESPONSIBLE FOR ACCOUNT – THAT PERSON MUST BE PRESENT TO SIGN!!!!

Please complete the section below, if someone other than the patient is responsible for the payment of services.

Name: _____ Relationship to Patient: _____
Street Address: _____ Apt#: _____ Date of Birth: _____ Home Phone: (____) _____
City: _____ State: _____ Zip: _____ Cell Phone: (____) _____
SS#: _____-_____-_____ Employer: _____ Work Phone: (_____) _____

PREFERRED METHOD OF PAYMENT

CASH ( ) CHECK (_____) CREDIT CARD (_____) CARE CREDIT (_____)

INSURANCE INFORMATION

Policy Holders Name: _____ Date of Birth: _____
Policy Holders ID#:_____ Group # _____ Insured's Relationship to Patient: _____
Insurance Company Name: _____
Please list any additional insurance on the back of this form, including all information as listed above.

HOW DID YOU HEAR ABOUT OUR OFFICE OR WHO REFERRED YOU?

Name: _____ Relationship: _____Phone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION

I grant authority, with my permission, to the doctor to perform necessary tests, for the establishment of my health profile and for the diagnosis of disease. I also grant authority, with my permission, to the doctor to provide treatment for any diagnosed illness that she and I deem necessary.

I understand that I am responsible for fees, at the time of service, for all in-house services (regardless of insurance payments). I also understand that I will be responsible for any portion of the doctors fee for hospital visits that my insurance does not cover.

I agree to pay finance charges of 1.5% per month (an Annual Rate of 18%) on any unpaid balance, after 90 days as well as collection fee cost and/or a reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

I hereby authorize the release of any information relating to my medical treatment and/or medical insurance claims to my insurance carrier.

Authorized Signature: _____ Date: _____

Parent of Minor or Guarantor: _____ Date: _____

Relationship to Patient: _____ Date: _____

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REVIEW OF SYSTEMS

Name _____ Date _____

*****ON EACH OF THE FOLLOWING QUESTIONS – IF YOUR ANSWER IS "YES" PLEASE MARK A "C" FOR CURRENT SYMPTOMS OR CONDITIONS AND A "P" FOR PAST ONES.*****

HAVE YOU EVER HAD	YES	NO
Chronic Headaches		
Problems with vision		
Glaucoma or Cataracts		
Decreased hearing		
Nose bleeds		
Sinus trouble		
Hoarseness		
Trouble swallowing		
Teeth or gum problems		

Dry cough		
Productive cough		
Lung disease – asthma, bronchitis or emphysema		

Chest pain with exercise		
Enlarged heart or heart failure		
Ankle swelling		
Heart palpitations		
High cholesterol or triglycerides		
High blood pressure		
Heart attack		

Change in bowel habits		
Constipation		
Diarrhea or blood in stool		
Indigestion, heartburn or gas		
Yellow jaundice or hepatitis		
Ulcers (stomach or duodenal)		
Hiatal hernia		
Gall stones		
Hemorrhoids		
Stomach x-ray (upper GI)		
Colon x-ray (lower GI)		
Colonoscopy or Procto		

Infections of kidneys or bladder		
Blood or protein in urine		
Kidney stones		
Trouble starting or holding urine		

HAVE YOU EVER HAD	YES	NO
Kidney x-rays (IVP)		
Problems with sexual desire or function		
Low Back pain		
Disc trouble		
Joint trouble		
Phlebitis or blood clots		
Leg pain with exercise		
Osteoporosis		

Unconsciousness from head injury		
Paralysis or stroke		
Dizziness (lightheadedness)		
Dizziness (room spins around)		
Convulsions or epilepsy		

Under active or overactive thyroid		
Thyroid goiter, nodule or tumor		
Hypoglycemia (low blood sugar)		
Diabetes Mellitus		

Skin cancers		
Cancer or blood disorder		
Chronic skin disease or rash		

Are you frequently ill?		
Do you have difficulty falling asleep or staying asleep?		
Are you considered a nervous person?		
Are you easily upset or irritated?		
Do you often cry?		
Do you feel unhappy or depressed?		

Please continue on the back of this page

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REVIEW OF SYSTEMS

WOMEN ONLY

	YES	NO
Breast lumps, tumors or discharge		
Hot flashes or vaginal dryness		
Surgery on your female organs		
Have you ever taken female hormones or birth control pills		

Age at beginning of menstruation
Age at end of menstruation
Irregular periods
Number of pregnancies
Number of miscarriages
Number of children born alive
Number of abortions
Last PAP smear date
Abnormal PAP smear
Last Mammogram (breast x-ray)
Birth Control Method

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PATIENT MEDICAL/FAMILY HISTORY

Name _____ **Date** _____

Please circle any of the following illnesses YOU have had:

Diabetes Mellitus	**Arthritis**	**Fibromyalgia**	**Autoimmune Disorder**	**AIDS**
High Blood Pressure	**Asthma**	**Heart Trouble**	**COVID 19**	
Cancer	**Thyroid Disorders**	**Kidney Disease**	**Sexually Transmitted Infection(s) (STI)**	

SURGERIES:	**Operations**	**Date**	**Doctor**	**Hospital**
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

MEDICAL HOSPITALIZATIONS:	**Illness**	**Date**	**Doctor**	**Hospital**
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

ALLERGIES TO MEDICINE & REACTION: _____
_____
_____

SOCIAL HISTORY

Marital Status: ***Please Circle*** **Single Partner Married Widowed Divorced**

Occupation _____ **How Long?** _____

HABITS:

Do you use tobacco now? _____ **In the Past?** _____ **Type/Daily Amount?** _____ **How Long?** _____
Do you use alcoholic beverages? _____ **Type?** _____ **Weekly Amount?** _____ **How Long?** _____
Hobbies: _____
Exercise regularly (other than work-related)? _____ **Type of Exercise?** _____

(Continued on back)

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PATIENT MEDICAL/FAMILY HISTORY

Name _____ **Date** _____ **Page 2**

Please check the immunizations you have had and date if known:

MMR _____ **Polio (oral)** _____ **TDap** _____ **COVID-19 (Manufacturer)**_____
Pneumovx (pneumonia vaccine) _____ **Influenza (flu shot)** _____ **Other** _____

_____

FAMILY HISTORY

	Living	Age or Age at Death	Present Health or Cause of Death
Father	**Yes**___ **No** ___	_____	_____
Mother	**Yes** ___ **No** ___	_____	_____
Spouse	**Yes** ___ **No** ___	_____	_____

Brothers **Number Living** _____ **Their Health:** _____
Number Deceased _____ **Cause of Death:** _____
Sisters **Number Living** _____ **Their Health:** _____
Number Deceased ____ **Cause of Death:** _____
Children Living _____ **Their Ages and Health:**_____
Children Deceased _____ **Cause of Death and Child's Age:** _____

DO ANY OF THE FOLLOWING DISEASES RUN IN YOUR FAMILY?

Heart Disease/Stroke	_____	**Relationship to You:** _____
Thyroid Disorders	_____	**Relationship to You:** _____
Diabetes Mellitus	_____	**Relationship to You:** _____
Osteoporosis	_____	**Relationship to You:** _____
Cancer of Breast	_____	**Relationship to You:** _____
Cancer of Colon	_____	**Relationship to You:** _____
Cancer (Other)	_____	**Relationship to You:** _____

ANY OTHER PERTINENT INFORMATION REGARDING YOUR HEALTH OR THE HEALTH OF A FAMILY MEMBER: _____

_____

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PATIENT INFORMED CONSENT

I authorize any physician, provider or staff member of Nurturing Optimal Wellness to have access to any and all of my medical records for the purpose of my care. I authorize the free exchange of any medical information between any providers that I see at Nurturing Optimal Wellness for the enhancement of my care. I realize that this exchange may involve discussion of my physical, emotional, and mental status, both past and present. I also authorize the release of any medical information necessary to initiate or expedite the processing of any insurance claim for services provided by any Nurturing Optimal Wellness' physician or provider. I further authorize and request that payment for such claims be made directly to me unless Nurturing Optimal Wellness request that payment be made to them.

PERSON AS EMERGENCY CONTACT: _____
(Name) (Relationship)

AT THE FOLLOWING NUMBERS: _____
(Please Indicate Home/Work/Cell)

NORMAL TEST OR LAB RESULTS AND/OR APPOINTMENT INFORMATION MAY BE:

Please check all that apply and fill in appropriate numbers.

____LEFT ON ANSWERING MACHINE/VOICE MAIL AT HOME # _____

____LEFT ON MY CELL #_____

____LEFT ON ANSWERING MACHINE/VOICE MAIL AT WORK#_____

____DISCUSSED WITH: _____
(Name) (Relationship)
AT THE FOLLOWING NUMBERS: _____
(Please Indicate Home/Work/Cell)

____DISCUSSED WITH: _____
(Name) (Relationship)
AT THE FOLLOWING NUMBERS: _____
(Please Indicate Home/Work/Cell)

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Parent, Guardian, or Power of Attorney's Signature for Minor or Dependent

_____ Date: _____

Relationship to Patient: _____

Witness's Signature: _____ Date: _____

CURRENT MEDICATIONS

Supplements

(other side)

Patient Name: _____ Date:_____

Start Date	Medication	Dose, Quantity & Time of Day Taken		

Date	Allergy or Sensitivity	Reaction

CURRENT SUPPLEMENTS

Medications

(other side)

Patient Name: _____ Date:_____

Start Date	Medication	Dose, Quantity & Time of Day Taken		

Date	Allergy or Sensitivity	Reaction