PATIENT DEMOGRAPHICS

Last Name, First Name, Middle Initial _____ Date of Birth _____ Gender _____

Address, City, State, Zip _____ Telephone Number _____

E-mail Address _____ Alternate Telephone Number _____

Marital Status _____ Spouse's/Partner Name _____ Spouse's/Partner Telephone Number _____

Emergency Contact Name _____ Emergency Telephone Number _____

Emergency Contact Address, City, State, Zip _____ Relationship To You _____

EMPLOYMENT INFORMATION

Employer _____ Occupation _____

Address, City, State, Zip _____ Work Telephone _____

Welcome to Wildwood Integrative Healthcare, Inc. We strive to assist patients restore their health through both conventional and alternative methods including drug and non-drug therapies, nutritional therapies, natural hormone balancing, extensive patient education and other modalities. We work to address the underlying cause of symptoms rather than covering them up – looking for the root cause of disease. We believe the human body has the innate ability to heal and that when a human body's systems are in balance there will be vibrant health. We strive to help our patients improve their health through wise lifestyle choices to promote healing – body, mind and spirit. Our goal is to provide kind and compassionate care.

This office values your privacy and follows all the terms and conditions of the Health Insurance Portability and Accountability Act (HIPAA). In doing so, you will be asked to designate, in writing, with whom we can share your private health information. Additionally, our staff is committed to providing care to all patients, regardless of race, skin color, national origin, age, sex, sexual orientation, disability, religious or political beliefs, with dignity and compassion.

CONSENT TO TREAT

My signature on this document authorizes the staff of Wildwood Integrative Healthcare, Inc. to perform examinations, order and interpret diagnostic tests, suggest treatments and/or therapies and take other actions that they consider medically necessary to diagnosis and treat my symptoms or illnesses. I further understand the practitioner treating me will consult and educate me on the suggested treatment(s) or therapy(s) before proceeding. I understand that I have the right to refuse any suggested examination, test, treatment or therapy. I also understand that the practice of healthcare is not an exact science and that no guarantees will be made to me as to the results or outcomes of my evaluations or treatments.

_____ _____

SIGNATURE DATE