Eric Cerré, NMD
Take back your life.

Welcome to Our Practice

Help us get to know you better!

Name _____ Age ____ DOB _____ Sex: ☐ M ☐ F

Address _____ City _____ State ___ Zip _____

Home Ph _____ Cell _____ Email _____

DL# _____ SSN# _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Employer _____ Work# _____

Emergency Contact _____ Phone# _____

Present Symptoms/Complaints _____

Referred by _____

Current Medications

List: name of medication, strength, dosage per day, and the prescribing doctor

1. _____
2. _____
3. _____

You can list additional medications on the back.

Allergies

Examples: medicines, chemicals, foods, perfumes, etc. **No Known Allergies:** ☐

1. _____ 3. _____
2. _____ 4. _____

You can list additional allergies on the back.

Surgical History

List: type of surgery and date

1. _____ 3. _____
2. _____ 4. _____

You can list additional surgical history on the back.

Imaging in the Last Two Years

List: date, part of body imaged, and location of imaging facility

X-Ray _____
MRI _____
CT Scan _____
Other (EKG, EMG, etc.) _____

You can list additional imaging on the back.

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Review of Symptoms

Check all that apply—past & present

General
- Weight loss/gain
- Fatigue
- Fever or chills
- Trouble sleeping

Skin
- Rashes
- Lumps
- Itching
- Color changes
- Hair & nail changes

Head
- Headache
- Head Injury
- Neck Pain

Ears
- Decreased hearing
- Ringing in the ears
- Earache
- Drainage

Eyes
- Vision loss/changes
- Glasses/contacts
- Pain
- Redness
- Blurry/double vision
- Flashing lights
- Specks
- Glaucoma
- Cataracts

Nose
- Stuffiness
- Discharge
- Itching
- Hay fever
- Nosebleeds
- Sinus pain

Mouth/Throat
- Bleeding
- Dentures
- Sore tongue
- Dry mouth
- Sore throat
- Hoarseness
- Thrush
- Non-healing sores

Neck
- Lumps
- Swollen Glands
- Pain
- Stiffness

Breasts
- Lumps
- Pain
- Discharge
- Self-exams
- Breast-feeding

Respiratory
- Cough
- Sputum
- Coughing up blood
- Shortness of breath
- Wheezing
- Painful breathing

Cardiovascular
- Chest pain/discomfort
- Tightness
- Palpitations
- Shortness of breath with activity
- Difficulty breathing lying down
- Swelling
- Sudden awakening from sleep with shortness of breath

Gastrointestinal
- Difficulty swallowing
- Heartburn
- Change in appetite
- Nausea
- Change in bowel habits
- Rectal bleeding
- Constipation
- Diarrhea
- Yellow eyes/skin

Urinary
- Frequency
- Urgency
- Burning or pain
- Blood in urine
- Incontinence
- Change in urinary strength

Vascular
- Calf pain with walking
- Leg cramping

Musculoskeletal
- Muscle/joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma

Neurologic
- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremor

Hematologic
- Ease of bruising
- Ease of bleeding

Endocrine
- Heat/cold intolerance
- Sweating
- Frequent urination
- Thirst
- Change in appetite

Psychiatric
- Nervousness
- Stress
- Depression
- Memory loss

ERIC CERRÉ, NMD 312 North Alma School Road, Suite 7, Chandler, AZ 85224 P: 480-821-8686 F: 602-225-2287

Disclosure of Potential Risks
of Trigger Point Injections

As with most procedures, there are potential risks. Listed below are some of the possible risks from Trigger Point Injections, **but this list is not all-inclusive** due to the individuality of each person. Every effort is made to reduce the possibility of any type of reaction.

1. Depending on the location of the trigger point, there is the possibility of puncturing body cavities such as the lung, abdomen, pelvic cavity, and corresponding blood vessels and nerves.
2. Possible infection of bruising at the injection site.
3. Possible reaction to medications used in the procedure.
4. Possible infiltration of medications into areas beside the intended injection site.

Trigger Point Injections are not a covered procedure under most health insurance. As a patient, I have been advised and understand the potential risks.

Patient Name _____ Signature _____ Date _____

Doctor Name Eric Cerré, NMD Signature _____ Date _____

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Consent
for Evaluation & Treatment

By signing this document, I authorize evaluation and treatment with Dr. Eric Cerré, a Naturopathic Medical Physician, and hereby understand, consent, and agree to the following:

1. I have been informed that Eric Cerré is a Naturopathic physician licensed to practice Naturopathic medicine in the State of Arizona (Lic. 09-1159). I understand that I will be treated with Naturopathic treatment modalities including but not limited to the following:
   - *Consult & Exam*
   - *Trigger Point Injection*
   - *Decompression*
   - *PRP/Stem Cell*
   - *Minor Surgery*
   - *P-Shot® Procedure*
   - *Hormone Therapy*
   - *Medication (Pain Management)*
2. Information developed as part of the evaluation/treatment is confidential but may be released to those parties as required by laws such as:
   - *In medical emergencies involving danger to self or to others*
   - *Upon presentation or reasonable suspicion of abandonment/neglect or physical/sexual abuse of a child or elder*
   - *A court order*
   - *Insurance billing claim requirements*
   - *Upon receipt of a properly executed consent form*
   - *And where otherwise legally required*
3. Treatment is individualized to specific needs and may result in emotional and physical discomfort through the treatment, healing, and recovery process.
4. Nothing should be constructed here in that there's a perfect remedy or treatment for those disease stats considered terminal or incurable.
5. You have the right to withdraw from this agreement at any time.

Patient Name _____ Signature _____ Date _____

Guardian Name _____ Signature _____ Date _____

Doctor Name Eric Cerré, NMD Signature _____ Date _____

Notice of Privacy Practices
for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Office is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We will not disclose your health information except as described in this Notice.

This Office is permitted by federal privacy laws to make uses and disclosures of your protected health information for purposes of treatment, payment, and healthcare operations. Protected health information is the information that we create and obtain in providing services to you.

Examples of uses of your health information for treatment purposes:

- *The medical history and treatment information we obtain will be recorded in a health record/chart.*
- *During the course of your treatment, Dr. Cerré may determine that he will need to consult with another specialist and will share that information with such specialist and obtain his/her input.*
- *Some health information will be shared with healthcare facilities in order to schedule procedures.*

Examples of uses of your health information for payment purposes:

- *We will submit a written or electronic request for payment to your insurance company (automobile or health) or attorney. The information released will include name, address, insurance identification, and other identifiable personal information. It will also include diagnoses, procedures, and supplies used.*
- *Your insurance company (automobile or health) may request additional information regarding your medical care before authorizing payment of your claim.*

Examples of the use of your health information for healthcare operations:

- *We may need to use your healthcare information is assist us in such functions as credentialing, medical transcription, or medical review. We will share the minimal information necessary to complete these processes.*

For the release of health information not related to treatment, payment, and our healthcare operations, a signed AUTHORIZATION form will be required.

Examples of disclosure of your health information not related to treatment, payment, or our healthcare operations:

- *Releasing your healthcare information to another physician.*
- *Completion of disability benefits applications.*

We require that protected patient information be kept out of patient traffic areas.

Patient Receipt
for Notice of Privacy Practices for Protected Health Information

Patient Name _____ DOB _____

Please check one:

- ☐ I have reviewed **but choose not to retain** a copy of Dr. Cerré's *Notice of Privacy Practices for Protected Health Information*.
- ☐ I have reviewed & retained a copy of Dr. Cerré's *Notice of Privacy Practices for Protected Health Information*.

Release of Your Health Information

Who may receive information regarding your Protected Health Information?
Check all that apply:

Spouse: ☐Y ☐N Name _____ DOB _____

Children: ☐Y ☐N Name _____ DOB _____

Name _____ DOB _____

Attorney: ☐Y ☐N Name _____ DOB _____

Other: Name _____

May we leave messages regarding appointments and other health information on your voicemail on the number listed on our forms? ☐Y ☐N

I understand this authorization may be changed or revoked at any time by submitting a written notification to Dr. Eric Cerré.

My signature below acknowledges that I have read the *Notice of Privacy Practices for Protected Health Information*.

Patient Signature _____ Date _____