

Eric Cerre, NMD
290 S Alma School Rd Ste. 5A,
Chandler AZ 85224
P-480.821.8686 F-602.225.2287

Welcome to my practice. Please complete the following information.

PERSONAL INFORMATION:

NAME: _____ Age _____ DOB _____ Sex: ___ M ___ F
ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____
PHONE: _____ HOMEPHONE: _____ EMAIL: _____
DRIVERS LICENSE: _____ SSN# _____ MARITAL STATUS: ___ S ___ M ___ D ___ W
EMPLOYER: _____ WORK # _____
EMERGENCY CONTACT: _____ PHONE# _____
PRESENT SYMTOMS/COMPLAINTS: _____
REFERRED BY: _____

CURRENT MEDICATIONS:

List your current medications, strength, dosage per day, doctor who prescribed medication. List additional meds on back.

1. _____
2. _____
3. _____

ALLERGIES: medicine, chemical, food, tape, perfume etc. NO KNOW ALLERGIES ____

1. _____
2. _____
3. _____

SURGICAL HISTORY: List type of surgery and date.

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

HAVE YOU HAD ANY OF THE FOLLOWING IN THE LAST 2 YEARS: List date, where you had the imaging, part of body imaged.

X-RAYS _____

MRI: _____

CTSCAN: _____

OTHER: (EKG, EMG, etc.): _____



Review of Systems: Check all that apply past and present

Patient Name: _____ Date: _____

General

- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble sleeping

Skin

- Rashes
- Lumps
- Itching
- Color changes
- Hair and nail changes

Head

- Headache
- Head injury
- Neck Pain

Ears

- Decreased hearing
- Ringing in ears
- Earache
- Drainage

Eyes

- Vision Loss/Changes
- Glasses or contacts
- Pain
- Redness
- Blurry or double vision
- Flashing lights
- Specks
- Glaucoma
- Cataracts
- Last eye exam

Nose

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

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 or discomfort
- Tightness
- Palpitations
- Shortness of breath with activity
- Difficulty breathing lying down
- Swelling
- Sudden awakening from sleep with shortness of breath

Gastrointestinal

- Swallowing difficulties
- Heartburn
- Change in appetite
- Nausea
- Change in bowel habits
- Rectal bleeding
- Constipation
- Diarrhea
- Yellow eyes or skin

Urinary

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

Vascular

- Calf pain with walking
- Leg cramping

Musculoskeletal

- Muscle or 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 or cold intolerance
- Sweating
- Frequent urination
- Thirst
- Change in appetite

Psychiatric

- Nervousness
- Stress
- Depression
- Memory loss

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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 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 is not a covered procedure under most health insurances. As a patient, I have been advised and understand the potential risks.

Patient Signature: _____

Doctor Signature: _____

Date: _____

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Consent For Evaluation and Treatment

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

1. I have been informed that Eric Cerre 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 and Exam
 - Trigger Point Injection
 - Decompression
 - PRP/Stem Cell
 - Minor Surgery
 - P-Shot/O-Shot
 - 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 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 states considered terminal or incurable.

5. You have the right to withdraw from this agreement at anytime.

Patient Name _____ Signature _____ Date _____

Guardian Name _____ Signature _____ Date _____

Doctor Name Dr. Eric Cerre, NMD Signature _____ Date _____

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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:

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

Examples of uses of your health information for payment purposes:

1. 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.
2. 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:

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

For 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:

1. Releasing your healthcare information to another physician.
2. Completion of disability benefits applications.

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

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**Patient Receipt for Notice of Privacy Practices
For Protected Health Information**

Patient's Name: _____ DOB: _____

Please check one:

I have reviewed, **but choose not to receive a copy** of Dr. Cerre's Notice of Privacy Practices for Protected Health Information.

I have reviewed and received a copy of Dr. Cerre'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: _____

Other: Name: _____

May we leave messages regarding appointments and other health information on your voice mail 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 Cerre.

My signature below acknowledges that I have read this Notice of our Privacy Practices.

Patient

Signature: _____ Date: _____