New Patient Questionnaire

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First MI Last

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Male \_\_ Female

Martial Status: \_\_Single \_\_Married \_\_Widowed \_\_ Divorced \_\_ Separated

If married, spouse’s name:

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If patient is a Minor, are parents \_\_Married \_\_Divorced Custodial Parent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party’s Home #: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #:(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party’s SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company # 1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

>>Primary Insured’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ >>Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

>>SS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ >>Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### What are your Health goals?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Vitals (if known):**

Height: Weight:

Blood Pressure: Pulse:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Condition | N/A | Myself | Sibling | Parents  Mother Father | Grandparents  Maternal Paternal |
| Heart Disease |  |  |  |  |  |
| Cancer |  |  |  |  |  |
| Diabetes |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |
| Arthritis |  |  |  |  |  |
| Liver Disease (i.e. hepatitis, cirrhosis) |  |  |  |  |  |
| Mental Health Issues (i.e. depression, anxiety, psychotic disorders) |  |  |  |  |  |
| Autoimmune Disease (lupus, rheumatoid arthritis) |  |  |  |  |  |
| Endocrine Gland Disorders (thyroid, adrenal, pituitary) |  |  |  |  |  |
| Neurological Disorders (i.e. stroke, seizures, Parkinson’s, Alzheimer’s, multiple sclerosis) |  |  |  |  |  |
| Lung Disease (i.e. asthma, emphysema, bronchitis) |  |  |  |  |  |
| Abnormal EKG |  |  |  |  |  |
| Kidney Disease (i.e. stones, infections, cysts) |  |  |  |  |  |
| Stomach/Esophagus Disorders (i.e. reflux, stricture, ulcers) |  |  |  |  |  |
| Bowel Disease (i.e. malabsorption, lactose intolerance, diverticulitis, Crohn’s, colitis, irritable bowel syndrome) |  |  |  |  |  |
| Bladder disease |  |  |  |  |  |
| Substance Abuse (i.e. alcohol, prescription, recreational drugs, tobacco) |  |  |  |  |  |
| Weight Control Problems |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |
| Migraine Headaches |  |  |  |  |  |
| Anemia |  |  |  |  |  |
| HIV/AIDS |  |  |  |  |  |
| Allergies |  |  |  |  |  |
| Memory Problems |  |  |  |  |  |
| Sleep Apnea/Snoring |  |  |  |  |  |

Please review the list of conditions and check the column(s) that most applies to you and your family history.

Are you allergic to any drugs? \_\_\_\_\_\_ If yes, please list the drug(s) and describe the reaction. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medication including dosage and frequency (prescription and/or over-the-counter) you currently take and the condition for which it is taken.

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | **Condition** | **Dosage** | **Times per day** |
|  |  |  |  |
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Please list all supplements including dosage and frequency (i.e. vitamins, herbs, nutritional supplements) you currently take

and the condition for which it is taken. An option is to copy the labels and forward them along with your completed

questionnaire.

|  |  |  |  |
| --- | --- | --- | --- |
| **Supplement** | **Condition** | **Dosage** | **Times per day** |
|  |  |  |  |
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Please list any surgical procedures you have had, including plastic surgery, along with the approximate date.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review of Overall Health

Under the categories listed below, check the “yes” column only if you are experiencing the listed symptom to a substantial or unusual degree.

Skin and Hair

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Dry/brittle and/or flaky hair |  |  |
| Dry/brittle skin |  |  |
| Acne |  |  |
| Age spots |  |  |
| Thick skin and fingernails |  |  |
| Puffy, wrinkled skin |  |  |
| Dark circles under eyes |  |  |
| Hair thinning or falling out or hair grows very slowly |  |  |
| Toe or fingernail fungus |  |  |
| Bumpy skin on face or back of arms |  |  |
| Spider veins in nose and/or face |  |  |
| Persistent rash/skin allergy |  |  |
| Hives |  |  |
| Sores, boils, or sties |  |  |
| Slow or poor wound healing |  |  |
| Excessive sweating or itching |  |  |
| Flushing or hot flashes |  |  |
| Bruise easily or excessively |  |  |

Allergies

|  |  |  |
| --- | --- | --- |
| Allergy | Yes | No |
| Seasonal Allergies—Describe Symptoms: |  |  |
| Food Allergies—List Type & Reaction: |  |  |
| Latex or Other Environmental Allergies—Describe Reaction: |  |  |

Joints/ Muscles/ Bones

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Joint pain, swelling or stiffness |  |  |
| Arthritis |  |  |
| Back pain |  |  |
| Limited motion |  |  |
| Muscle tension or spasms |  |  |
| Fibromyalgia |  |  |
| Carpal Tunnel Syndrome |  |  |

Cardiopulmonary

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Pain in the left side under the rib cage |  |  |
| Pain in the right side under the rib cage |  |  |
| Pain in the left arm |  |  |
| Chest pain at rest or while walking, running, or lifting weights |  |  |
| Other pain in chest or sides |  |  |
| Frequent and recurring upper respiratory infections or colds/flu |  |  |
| Fluid retention (e.g., swollen ankles, legs, etc.) |  |  |
| Cannot tolerate much exercise |  |  |
| Difficulty breathing |  |  |
| Chronic lung congestion |  |  |
| Wheezing |  |  |
| Heaviness in legs |  |  |
| Calf muscle cramps while walking |  |  |
| Heart pounds easily |  |  |
| Heart misses beats or has extra beats |  |  |
| Rapid heartbeat, fluttering |  |  |
| Shortness of breath |  |  |
| Heartburn after eating |  |  |
| Exhaustion with minor exertion |  |  |
| Erratic blood pressure |  |  |
| High blood pressure |  |  |
| Low blood pressure |  |  |
| Breathing problems at night |  |  |
| Difficulty lying flat |  |  |

Eyes/Ears/Nose/Throat

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Change in vision |  |  |
| Blurred or tunnel vision |  |  |
| Double vision |  |  |
| Balance problems |  |  |
| Hearing loss |  |  |
| Ringing in ears |  |  |
| Ear pain |  |  |
| Ear drainage |  |  |
| Nosebleeds |  |  |
| Stuffy nose |  |  |
| Sore throat/hoarseness |  |  |
| Sinus infections |  |  |
| Sore or bleeding gums |  |  |
| Canker sores or cold sores |  |  |
| Difficulty swallowing |  |  |

Metabolic

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Certain foods cause ill feelings |  |  |
| Difficulty gaining weight |  |  |
| Difficulty losing weight |  |  |
| Bad breath (no relief by brushing) |  |  |
| Body odor (no relief by washing) |  |  |
| Total blood cholesterol above 200 |  |  |
| HDL cholesterol below 50 |  |  |
| LDL cholesterol above 130 |  |  |
| Swollen (bulging) eyes |  |  |
| Hypersensitive to the cold |  |  |
| Cold hands and feet |  |  |
| Thinning or loss of outside portion of eyebrow |  |  |
| Gain weight easily |  |  |
| Body temperature below 97.6 degrees Fahrenheit |  |  |
| Crave salt or salty foods |  |  |
| Blushing with no apparent cause |  |  |
| Irritable if meal is missed |  |  |
| Wake up in the middle of the night craving sweets |  |  |
| Feel tired or weak if meal is missed |  |  |
| Heart palpitations after eating sweets |  |  |
| Need to drink caffeine to get going |  |  |
| Feel tired 1 to 3 hours after eating |  |  |
| Feel faint or weak |  |  |
| Night sweats |  |  |
| Increase thirsts |  |  |
| Overweight |  |  |
| Crave sweets (but eating sweets does not relieve symptoms) |  |  |
| Weight change of more than 10 lbs. in the last six months |  |  |

Miscellaneous

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Frequent infections or illness |  |  |
| Change in appetite |  |  |
| Fatigue |  |  |
| Apathy/lethargy |  |  |
| Lumps in neck, armpits, groin or breast |  |  |
| Broken bone(s) as an adult |  |  |
| Insomnia |  |  |
| Hypersomnia (sleeping too much) |  |  |
| Sleep Apnea |  |  |
| Difficulty getting out of bed in the morning |  |  |
| Other symptoms (please list) |  |  |

Kidney/Bowels/Bladder/Gastrointestinal

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Frequent urination or scant urination/dribbling |  |  |
| Burning during urination |  |  |
| Loss of bladder control (including leaking) |  |  |
| Hemorrhoids |  |  |
| Excessive nighttime urination (specify number of times) |  |  |
| Loss of bowel control |  |  |
| Blood in urine |  |  |
| Blood in stool |  |  |
| Kidney stones |  |  |
| Frequent urinary tract infections |  |  |
| Diarrhea |  |  |
| Constipation (hard or effortful bowel movements) |  |  |
| Difficulty urinating |  |  |
| Abdominal pain |  |  |
| Nausea and/or vomiting |  |  |
| Heartburn/reflux |  |  |
| Difficulty swallowing or pain with swallowing |  |  |
| Flatulence (gas) or bloating |  |  |
| Gallbladder problems |  |  |
| Dependency on Antacids |  |  |

Neurological

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Headaches |  |  |
| Faintness |  |  |
| Seizures/convulsions |  |  |
| Tremors |  |  |
| Dizziness |  |  |
| Tingling or numbness |  |  |
| Balance problems |  |  |
| Paralysis |  |  |
| Muscle weakness |  |  |
| Uncoordinated |  |  |
| Difficulty walking |  |  |
| Difficulty speaking |  |  |
| Memory problems |  |  |
| Loss of smell or taste |  |  |
| Problems with attention and concentration |  |  |

Mind and Emotions

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Rapid mood swings |  |  |
| Impatient, moody, nervous |  |  |
| Lack of mental alertness |  |  |
| Depression |  |  |
| Anxiety/fear |  |  |
| Lack of self-esteem |  |  |
| Difficulty with memory, attention, or concentration |  |  |
| Short attention span |  |  |
| Personality changes |  |  |
| Sleep disturbances |  |  |
| Short temper/anger/irritability |  |  |
| Excessive worrying |  |  |
| Suicidal thoughts |  |  |
| Confusion/poor comprehension |  |  |
| Difficulty making decisions |  |  |
| Excessive stress |  |  |
| Restlessness, hyperactivity, or inability to relax |  |  |
| Weakness, fatigue, or loss of energy |  |  |
| Frequent infections |  |  |

For Men … Continue below

For Women … Go to Page 10

For Men

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Difficulty maintaining/attaining an erection (or insufficient to maintain penetration) |  |  |
| Ejaculation causes pain |  |  |
| Sexual drive under active |  |  |
| Sexual drive overactive |  |  |
| Premature ejaculation |  |  |
| Pain/coldness in genital area |  |  |
| Infertility |  |  |
| Varicose veins on scrotum |  |  |
| Low sperm count |  |  |
| Discharge from penis |  |  |
| Lack of early morning erections |  |  |
| Past or present rash on penis |  |  |
| Swollen genitals |  |  |
| Swelling in groin |  |  |
| Genital sores |  |  |
| Lump or mass in scrotum |  |  |
| Jock itch |  |  |
| Past or present sexually transmitted disease (specify): |  |  |

|  |  |  |
| --- | --- | --- |
| Medication | Yes | No |
| Do you use Viagra, Cialis, Levitra or any other erectile enhancement drugs?  If yes, which one(s) and how often? |  |  |
| Have they helped you? |  |  |
| Do you use any other medication for sexual function?  If yes, please list and describe results: |  |  |
| Have you ever used testosterone, HCG, DHEA, or hGH?  If yes, which one(s) and when? |  |  |

Please provide the most recent date and results for the tests listed below.

|  |  |
| --- | --- |
| Test Dates | Results |
| Prostate exam |  |
| PSA |  |
| Colonoscopy |  |
| Sigmoidoscopy |  |
| Rectal exam |  |
| Resting EKG |  |
| Stress EKG |  |
| Stress Echo |  |
| Nuclear Stress |  |
| Chest X-ray |  |
| Eye exam/eye pressures |  |

For Women

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Missed or irregular periods |  |  |
| Pelvic or vaginal soreness or pain |  |  |
| Menstrual pain |  |  |
| Heavy menstrual bleeding |  |  |
| Infertility |  |  |
| Hot flashes/night sweats |  |  |
| Under active sex drive |  |  |
| Overactive sex drive |  |  |
| Pre-menstrual syndrome (PMS) |  |  |
| Bloating and swelling |  |  |
| Tender breasts |  |  |
| Low backache |  |  |
| Vaginal itching |  |  |
| Vaginal discharge or sores |  |  |
| Past or present sexually transmitted disease (specify): |  |  |
| Dislike of intercourse |  |  |
| Pain in ovaries |  |  |
| Sweating throughout the day |  |  |
| Vaginal dryness |  |  |
| History of miscarriages |  |  |
| History of ovarian cysts |  |  |
| History of uterine cysts/fibroids |  |  |
| History of endometriosis |  |  |
| Have you had a hysterectomy?  If yes, please provide the date and reason. |  |  |
| Have you ever taken estrogen, progesterone, testosterone, DHEA, or hGH?  If yes, which one(s) and when? |  |  |
| What form of birth control do you use? | | |

Age Onsent of Menses: \_\_\_\_\_\_\_\_ years

Age at Menopause: \_\_\_\_\_\_\_\_ years

Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnancy History:

Total pregnancies: \_\_\_\_\_\_ Full term: \_\_\_\_\_\_ Pre-term: \_\_\_\_\_\_

Miscarriages: \_\_\_\_\_\_ Living: \_\_\_\_\_\_

Please provide the most recent date and results for the tests listed below.

|  |  |
| --- | --- |
| Test Dates | Results |
| Pap smear, Pelvic exam |  |
| Breast exam |  |
| Mammogram |  |
| Colonoscopy |  |
| Rectal exam |  |
| EKG |  |

Please provide a timeline of events for Dr. Lamkin including Physicians seen, symptoms experienced, and treatments

administered. This will save us time during your appointment and help us prepare for your visit. Please be as detailed as

possible

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## 

## Lifestyle Summary

How many servings of an alcoholic beverage do you consume in an average week? Note: A serving is defined as a 12-ounce beer, 5-ounce glass of wine, or 1.5 ounces of liquor.

Do you currently or previously use tobacco? If yes, please specify type, frequency, date quit:

## Exercise Summary

On a regular basis, over the last 3 months, indicate the number of days per week you performed the following activities.

* 1. Aerobic exercises (swimming, walking, jogging, cycling, stationary bike) \_\_\_\_\_
  2. Resistance training exercises \_\_\_\_\_\_
  3. Stretching exercises \_\_\_\_\_\_

If you do aerobic exercise, how long is your average workout? \_\_\_\_\_

What is the intensity of your aerobic exercise?

|  |  |
| --- | --- |
| Very Light | Stretching |
| Light | Includes some movement as in leisure walking |
| Moderate | Continuous movement causing increase in heart rate (brisk walking, leisure swimming) |
| Heavy | Continuous movement involving fluctuation in intensity from moderate to heavy with significant increases in heart rate |
| Very heavy | Continuous movement causing heaving breathing, sweating, marked increases in heart rate, etc. |

**Nutritional Summary**

|  |  |  |
| --- | --- | --- |
| Question | Yes | No |
| Are you preoccupied with certain foods and the thought of food? |  |  |
| Has your eating ever interfered with any part of your life? |  |  |
| Do you keep your feelings about food and eating a secret? |  |  |
| Has your weight gone up and down over the years? |  |  |
| Have you ever lied about how much sweet food or other carbs you eat? |  |  |
| Is it possible to “just say no” to sweet foods and other processed carbohydrates? |  |  |
| Are sugar/carbs controlling your life? |  |  |
| Have you had short-term success in controlling your eating only to slip back into uncontrollable, excessive eating of the foods you are trying to avoid? |  |  |
| Do you continue to binge despite its adverse consequences on your life and health? |  |  |
| Are you a vegetarian?  What type: |  |  |

I hereby acknowledge that I have received the Notice of Privacy Practices of The Lamkin Clinic.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additionally, I authorize The Lamkin Clinic to communicate with me via:**

* Email
* Phone
* Leaving messages
* Fax
* Mail

**Acknowledgement Refused**

On this date, the undersigned patient refused or failed to acknowledge receipt of the Privacy

Practices Notice.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for refusal/failure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

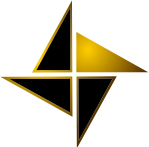
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Signature of Witness:

**\* Signed Copy will remain with Patient’s Record \***



The Lamkin Clinic...for optimum health

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Dr. Lamkin providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine.

I understand that I will be responsible for payment for my telemedicine consult. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I may revoke my consent orally or in writing at any time by contacting Dr. Lamkin 405.285.4762. As long as this consent is in force (has not been revoked) Dr. Lamkin may provide health care services to me via telemedicine without the need for me to sign another consent form.

I understand that in most circumstances Dr. Lamkin can fully evaluate you, treat and manage your care via telemedicine, but that in certain circumstances, based on the information discussed during the consultation, Dr. Lamkin may require you to come in to the office for an exam before treatment or full recommendation can be made 2) Dr. Lamkin may still may need to refer you to a specialist for further evaluation and/or 3) Dr. Lamkin may refer you to an ER for an immediate evaluation.

Signature of Patient (or person authorized to sign for patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_

Printed Name of Patient/Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If authorized signer, relationship to patient: Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

I have been offered a copy of this consent form (patient’s initials):\_\_\_\_\_\_\_\_\_\_

Patient Authorization for Healthcare Communications

*The Lamkin Clinic* offers patients the opportunity to communicate by email and/or text messaging for healthcare matters and may be used to discuss non-sensitive, non-urgent matters. Appropriate matters may include scheduling, appointment reminders, doctor recommendations, dietitian recommendations, pricing/product information, questions about medications/supplements, reporting of self-monitoring measurements such as blood pressure, food logs, blood pressure logs.

Although the *Lamkin Clinic* has implemented reasonable technical safeguards, the *Lamkin Clinic* cannot and does not guarantee the privacy, security or confidentiality of any text or email messages sent or received. There is a potential that Email or text messages sent or received can be intercepted, altered, forwarded, and/or read by others. The *Lamkin Clinic* is not responsible for messages that are lost due to technical errors/failure during composition, transmission or storage.

Email and/or text messages regarding treatment, medications, patient specific correspondence will be documented in your medical record by placing a copy of each message in your file.

\_\_\_\_\_\_ (initial) I consent to receiving text and/or email messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future communication unless I request a change in writing (see revocation section below)

The cell phone number that I authorize to receive text messages from the *Lamkin Clinic* is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The email address that I authorize to receive email messages from the *Lamkin Clinic* is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of Email and/or text messaging as one form of communication with the *Lamkin Clinic.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if other than patient)

***Revocation:***

***I hereby revoke my request for future communications via email and/or text.***

*\_\_\_\_\_\_ (initial) I hereby revoke my request to receive any future appointment reminders, feedback, and general health correspondence via text messages.*

*\_\_\_\_\_\_ (initial) I hereby revoke my request to receive any future appointment reminders, feedback, and general health correspondence via email.*

*NOTE: This revocation only applies to communications from the Lamkin Clinic.*

*Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Patient/Patient Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Authorized Release Patient Medical Record

**For:**

I, hereby authorize the following individual(s) as my Authorized Representative(s) on my behalf. Unless specified below, this individual(s) shall be granted full access to my Lamkin Clinic medical records, including, but not limited to; current and past prescriptions, refill requests, lab requisitioning and results, consultations and scheduling, transaction history, and medical records.

Authorized Representative(s):

Name: Contact Phone:

Name: Contact Phone:

The above referenced individual(s) have the following authority:

*Please initial appropriate choice(s)*

Full authority[[1]](#footnote-1).

Limited authority:

Prescription Refill Requests Scheduling Consultations

\_\_\_\_\_ Request of Medical Records \_\_\_\_\_\_Transaction(s) Review

Lab Fee Approval

I understand that by signing below, I authorize the listed Representative(s) to act on my behalf as I have indicated above. I agree to pay all charges for services and products requested by my assigned representative(s) on my behalf. I also understand that charges for prescriptions, program fees and/or lab fees are non-refundable as outlined in the Program Definitions I have received and read. I acknowledge that I have the right to cancel this designation at any time, via written and signed request, to The Lamkin Clinic.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_

Patient Signature Date

Lamkin Clinic Payment Schedule

Insurance Billing:

We do not bill insurance for your Physician or Dietitian consultations, however, we will offer assistance in providing appropriate coding so you can submit for reimbursement to your insurance company. Such services include, but are not limited to, physician consultations, exams, dietitian consultations, etc.

Appointments are reserved with a credit card. A forty-eight hour notice is required to cancel or reschedule an appointment. A $125 fee is charged for cancellations shorter than forty-eight hours. By signing below you express understanding and agree to these terms.

Consultation Fees:

* New Patient Consultation $375
* High Complexity Follow-Up Consultation/Lab Review  $225
* Moderate Complexity Follow-Up Consultation/Lab Review  $135-$175
* Sick visit $85
* Ecg (electrocardiogram) $50
* In-office procedures $125-$225
* Bone density scans $75 (for non-patients: $125)
* Body composition testing & analysis $75 (for non-patients: $125)
* Resting Metabolic Rate (RMR) testing $75 (for non-patients: $150)
* Initial Nutrition Consultation/Health Coaching  $110/hr
* Follow-up Nutrition/Health Coaching $60
* Low Dose Immunotherapy $35 Per Antigen mix
* Platelet Rich Plasma (Variable)
* In-Office Flu, Strep, Mono, Pregnancy, Urine testing $25 each

Nutritional Supplements:

The supplements recommended are of the highest quality and are felt to be essential for returning your body to optimum health.

Prescription Medications:

As a patient, you will have access to an in-clinic dispensary that provides reduced cost medications. *This service will not be provided for non-patients.*

Account Updates:

It may be necessary to update the form of payment on your account. All terms and

conditions of this agreement are applicable to any additional forms of payment provided

I hereby acknowledge and understand the Clinic Fee Structure that is detailed for me above.

Client Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclaimer for Health Insurance Benefit**

Client acknowledges that The Lamkin Clinic has made no representation or warranty that the treatment, service, or any portion thereof qualifies or will qualify for reimbursement or assignment under any insurance program.

Client hereby agrees to indemnify The Lamkin Clinic and its staff members against any claim, action, loss or suit and associated costs (including attorneys fees) which result either directly or indirectly from submission by the client (or his or her authorized agent or representative) of a claim.

After discussing the matter with The Lamkin Clinic staff, I have elected to have the services provided at my own expense.

Print Name:

Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Date:

**Patient Authorization to Charge Credit Card**

I authorize one of the following payment methods:

🞏 VISA/MasterCard 🞏 Discover 🞏 American Express

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CID Code** (3 digits found on Visa, Mcard & Discover in the signature field on the back of the card. 4 digits printed on face of Amex card to right of account number)

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize charges of the following when applicable

* Routine and Specialty Lab work
* Nutraceutical Supplementation
* Physician and Dietitian Consultations
* In-office procedures

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_

Patient’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Full Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Signature (If someone other than patient)

1. 1 Full authority includes, but is not limited to: Request for refills, approval of lab services, approval of professional fee charges, consultation scheduling, medical record requests and transaction reviews. [↑](#footnote-ref-1)