Janis L. Enzenbacher, MD
Isadora Guggenheim, FNP

Name ____ Date ________________
Address____
City______________________ State __________________ Zip _________________
Phone (H)___________________ (C) __________________(W) ________________ Ext:_____
Date of Birth ___________________ Age ______________ Gender: Female _____ Male _____ Other _____
Email ____ SSN ____________________________
Blood Type: ____________________ Ethnicity ___________________________
Religion/Belief System: __________________________________
Occupation ______________________________ Full Time / Part Time (Circle one)
Highest Level of Education ______________________________
Name and Phone of Primary Physician: _____________________________ Phone: _______________
Pharmacy (Name, Address, Phone #) ____

____

Referred By/ How did you hear about us? ____
For Confidential Information (i.e. test results), OK to leave detailed message: (check all that apply)
___ Home Phone ___Cell Phone ___Work Phone ___ E-Mail ___ US Mail___ Other ________________

EMERGENCY CONTACT INFORMATION

Emergency Contact ________________________ Relationship ______________________________
Telephone Number(s) ____
Additional Contact__________________________ Relationship _____________________________
Telephone Number(s) ____

Insurance Information

Name of Insured if Different than Patient: ____
Primary Insurance Name & Plan/ Medicare/ Medicaid: ___________________________________
Policy I.D. Number: _________________________________

E-MAIL CONTACT

E-mail offers a convenient way for us to communicate, however there are certain things to keep in mind.

- E-mail is never appropriate for urgent problems. For emergency, call 911, or go directly to the Emergency Department.
- E-mail is great for quick questions, prescriptions, referrals, etc. However, for topics that require extensive discussion, please make an appointment.
- E-mail is not confidential. If you correspond via e-mail at work, your employer has a legal right to read your e-mail.
- E-mails are saved and become part of your permanent medical record.
- Either one of us may revoke permission to e-mail at any time.
- **By signing below, I agree to communicate via e-mail. I have read the above information and understand the limitations of security on information transmitted inside these communications.**

______________________________________ ______________________________________

Signature of patient or legal guardian Print name

PLEASE COMPLETE THIS FORM AS THOROUGLY AS POSSIBLE. THANK YOU

Height: __________ **Weight: ____________**

Main Reason for Visit(s): ____

Please describe the history of your illness in detail. (i.e. symptoms, and any medical testing you've had done)

____

____

____

____

Any Major Health Conditions You Have Been Diagnosed With:
PLEASE MARK WITH THE YEAR DIAGNOSED (Do not mark with a "check")

______ Acne	_____ Diverticulosis/Diverticulitis	_____ Lupus
______ ADD/ADHD	_____ Eczema	_____ Lyme Disease
______ Anemia	_____ Epilepsy	_____ Migraine
______ Anorexia	_____ Fibromyalgia	_____ Multiple Sclerosis
______ Anxiety	_____ Gallbladder Disease	_____ Neuropathy
______ Asthma	_____ Glaucoma	_____ Osteoarthritis
______ Autoimmune Disorder	_____ Head Injury	_____ Osteoporosis
Describe: ___________________	_____ Headache	_____ Parasites
______ Bleeding/Blood Clot(s)	_____ Heart Attack	_____ Parkinson's
______ Bronchitis	_____ Heart Disease	_____ Psoriasis
_____ Cancer/Tumors	_____ Heart Murmur	_____ PTSD
_____ Cataracts	_____ Hepatitis (B / C)	_____ Reflux/Hiatal Hernia/Ulcer
_____ Cholesterol (High)	_____ Herpes Virus(Type 1/ Type 2)	_____ Restless Leg Syndrome
_____ Chronic Fatigue Syndrome	_____ High Blood Pressure	_____ Rheumatoid Arthritis
_____ Chronic Pain	_____ HIV/AIDS	_____ Seizures
_____ COPD	_____ Irritable Bowel Syndrome	_____ Sleep Apnea
_____ Coronary Artery Disease	_____ Irritable Bowel Disease	_____ Stroke/ TIA
_____ Crohn's	_____ Kidney Stones	_____ Substance Abuse
_____ Depression	_____ Liver Disease	_____ Thyroid Disease (Hypo/ Hyper)
_____ Diabetes (Type 1/ Type 2)	_____ Lung Disease	_____ Ulcerative Colitis

Hospitalizations/Procedures/ Surgeries: Please list all past hospitalization reason, with dates:

1) ____ Date: ____________________

2) ____ Date: ____________________

3) ____ Date: ____________________

4) ____ Date: ____________________

Family History: Please fill out thoroughly.

	DOB / AGE	Health Condition(s)	Status (i.e Living, deceased)	Comments
Mother				
Father				
Sister(s)_				
Brother(s)				
Daughter(s)				
Son(S)				

Any other comments pertaining to your family history:

____

____

____

Social/ Lifestyle:

Marital Status: Married ____ Partner ____ Single ____ Widowed ____ Divorced ____

Living Will: Yes ____ No _____

Power of Attorney: Yes _____ No ______

Highest Level of Education: ____

Employment Status: __________________________________

Occupation: ____________________________

Recent Foreign Travel: Yes _____ No ____ If Yes, where: ____

Smoker: ____ Currently ____ Past ____ Never Quit (year): __________

Cigarettes (# per day) ________________ # of Years_______

Alcohol: Yes ______ No ______ If Yes, how much: __________________ Quit(year): _________

Recreational drugs: Yes ______ No ______ Describe: _______________________________________

Coffee: Yes ______ No ______ # cups per day: _________

Tea: Yes ______ No ______ # cups per day: _________

Water: # of glasses per day ___________

Other caffeine sources: Yes ______ No ______ Type: _______________________________

Physical Exercise: Yes ______ No ______ Type: ____

How often per week and duration? _________________________________

Diet: ___ Vegan ___ Vegetarian ___ Carnivore Other: _________________

Any dietary restrictions: ________________________ Have you had an eating disorder? ____________

Sleep: (hours/night) ________ Quality? __________ Do you feel rested on waking? _______

Do you have trouble falling asleep or staying a sleep? ______________________________________

What are the significant stressors in your life? ____

____

Allergies:

Type:	**Start Date:**	**Reaction:**	**Severity:**	**Status:**
__________	_________	_____________________	________	___________________
__________	_________	_____________________	________	___________________

Any contraindication to Heparin: Yes ____ No ____

CURRENT MEDICATIONS

<u>Prescription Medications:</u>

Name	Dosage	Reason Taken	Taken for How Long?
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

<u>Over the Counter Medications, Vitamins, Supplements:</u>

Name	Dosage	Reason Taken	Taken for How Long?
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Preventative Care: (i.e. blood tests, colonoscopy, pap smear, mammograms, bone density, PSA test etc.)

Date	Preventative Care	Comments
______________	______________________________	____
______________	______________________________	____
______________	______________________________	____
______________	______________________________	____

Are you up to date on your vaccines? ____ Yes ____ No

Did you receive the usual childhood vaccinations? ____ Yes ____ No

Have you reacted to a vaccination in the past? ____

Which Vaccine? _________________________

Review of Systems:

Please check **ANY AND ALL** of the following that applies to you

1. Constitutional	
Fever	
Appetite Change	
Malaise	
Chills	
Sweats	
Unexplained Weight Loss	
Unexplained Weight Gain	
Fatigue	
Change in Energy/Weakess	
2. Skin	
Rash	
Mole Change	
Increased/Unusual Hair Growth	
Hair Loss/ Thinning	
Nail Changes	
Itching	
Abnormal Sun Exposure	
3. Eyes	
Change in Vision	
Watery	
Dry	
Itching	
Blurring	
Irritation	
4. Ears/ Nose/ Mouth & Throat	
Earache	
Difficulty Hearing	
Infection	
Tinnitus	
Congestion	
Runny Nose	
Loss of Smell	
Frequent Sore Throat	
Bleeding Gums	
Mouth Sores	
Swollen Glands	
Tonsil Issues	
Dental Problems	
5. Respiratory	
Coughing	
Wheezing	
Difficulty Breathing	
Coughing up Blood	

6. Cardiovascular	
Chest Pains/Discomfort	
Palpitations	
Murmurs	
7. Breast	
Breast Lump(s)	
Nipple Discharge	
Pain	
Fibrocystic Breasts	
8. Gastrointestinal	
Abdominal Pain	
Diarrhea	
Undigested Food In Stool	
Blood in Bowel Movement	
Constipation	
Nausea	
Heartburn/ Reflux	
Vomiting	
Excess Gas/ Bloating	
Ulcer	
Hemorrhoids	
Rectal Itchiness	
Bowel Movements Per Day ______	
9. Blood/ Lymphatic	
Easy Bruising	
Swollen Glands	
Clotting Issues	
Easy Bleeding	
10. Musculoskeletal	
Muscle or Joint Pain	
Muscle Weakness	
Back/Neck Pain	
Muscle Spasms	
11. Endocrine	
Hot or Cold Intolerance	
Abnormal Thirst	
Hypoglycemia	
Excessively Dry Skin	
Hot Flashes/Flushes	
Hypoglycemia	

13. Neurological	
Headaches	
Loss of Coordination	
Dizziness/Lightheaded	
Brain Fog	
Numbness	
Vertigo	
Memory Loss	
Fainting	
Balance Issues	
14. Genitourinary/ Women's Reproductive Health	
Nighttime Urination	
Excessive Urination	
Kidney Pain	
Discomfort, Burning, Irritation, Itching of the Vulva	
Blood in Urine	
Leaking Urine	
Vaginal/ Vulvar Dryness	
Vaginal Bleeding	
Painful Intercourse	
Vaginal Discharge	
Lesions	
Irregular Cycles	
Dysmenorrhea	
PMS	
Heavy Menses	
Last Menstrual Period: ___________	
STD: Describe: ____________________	
15. Genitourinary (Male)	
Nighttime Urination	
Excessive Urination	
Kidney Pain	
Leaking Urine	
Blood In Urine	
Penile Discharge	
Testicular Mass(es)	
Testicular Pain	
Lesions	
STD: Describe: ____________________	

16. Sexual Function (M/F)	
Low Desire	
Low Arousal	
Orgasm Difficulty	
Erectile Dysfunction	
17. Psychiatric	
Anxiety	
Stress	
Insomnia/ Sleep Disturbances	
Depression	
Mood Disorders	
History of Abuse	
ADD/ ADHD	
Addiction	
Do you enjoy your job?	
18. Other	
Mold Exposure	
Parasitic Disease	
Candidiasis	

Pain: Please list anywhere you are currently experiencing pain:

1. ____
2. ____
3. ____

Please use the space below to add any information that has not been covered in this questionnaire.

____

____

____

____

____

____

FOR PRACTITIONER USE ONLY

Notes:

____

____

____

____

Assessment & Diagnosis:

____

____

____

Plan: ____

____

____

Follow- up:____

____

Health Care Practitioner Signature: ________________________________ Date: __________

Patient Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

PLEASE REVIEW THIS NOTICE CAREFULLY

If you have any questions about this notice or if you need more information, please contact

Janis L. Enzenbacher, MD & Isadora Guggenheim, FNP
Attn: Privacy Officer
(845)358-8385
8 Rockland Pl
Nyack, NY 10960

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive from Janis L. Enzenbacher, MD & Isadora Guggenheim, FNP. We need this record to provide care (treatment), for payment of café provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions
- The provision of health care to you, or
- The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

- Treatment.
- Payment.
- Health Care Operations.
- Appointment Reminders / Treatment Alternatives/ Health- Related Benefits and Services.
- Minors.
- As Required by Law.
- To Avert a Serious Threat to Health or Safety.
- Military and Veterans.
- Public Health Risks.
- Abuse, Neglect, or Domestic Violence.
- Lawsuits and Disputes.
- Coroners, Medical Examiners, and Funeral Directors.

- **Uses and Disclosures that Required Us to Give You an Opportunity to Object and Opt Out.**
- **Individuals Involved in Your Care**. Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement.
- **Payment for Your Care.** Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.

Your Written Authorization if Required for Other Uses and Disclosures
The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures or PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to **30 days** to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs –based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Receive Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.
- **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.
- **Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: **http:**//www.secondnaturecare.com or contact our office.
- **Changes to This Notice**
  We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.
- **Complaints.**
  If you believe your privacy rights have been violated, you may file a complaint with the **Janis L. Enzenbacher, MD**, Privacy Officer, at the address listed at the beginning of this Notice or with the Department of Health and Human Services of the United States. **You will not be penalized for filing a complaint.**

Notice Effective 9/23/2013

Janis L. Enzenbacher, MD & Isadora Guggenheim, FNP
ACKNOWLEDGEMENT OF RECEIPT OF
PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/ or received a copy of the Janis L. Enzenbacher, MD & Isadora Guggenheim, FNP: Patient Notice of Privacy Practices/ HIPPA effective January 1, 2015

Date: ___________

Print Name: _____________________

Patient Signature: _______________________________
(or guardian, if applicable)

Please be advised that I _________________________ do not want give any authority or consent to give out any information of my medical history or diagnosis with any party. Under no circumstances should my medical history be given to anyone.
Date: _________

Patient Signature: _________________________________

PRACTICE POLICY & PAYMENT AGREEMENT:

Payment for all services including; ALL CONSULTS, IV THERAPIES, OZONE THERAPIES, PROLOZONE TREATMENTS, HOMEOPATHIC REMEDIES, NATUROPATHIC MEDICAL CARE, SUPPLEMENTS, HCG & INJECTABLE ADD-ONS, must be paid in full at the time of the visit for services rendered.

Payment can be made with credit card, cash or check. We charge a processing fee for all returned checks. Outstanding balances beyond 30 days will be charged a monthly interest fee of 1.5%.

The above services are not typically covered by medical health insurance companies including Medicare. Upon request, we can provide a receipt for services rendered. All services above are non-refundable.

I, ____, understand that I am responsible for the balance of my account, for any and all professional services rendered on my behalf. I accept full responsibility for the payment of these services.

Cancellation Policy

Cancellations for all appointments must be made within 24 hours of the scheduled appointment. This can be done by leaving a message at (845)358-8385 or (845)893- 2608 or email at isadoraguggenheim@msn.com. If the appointment is not cancelled within this time period then you will be charged 75% of the cost of service. Exceptions will be made with the discretion of practitioner.

Print Name ______________________________

Signature _______________________________ Date ____________