

Inside Passage Natural Medicine
800 Glacier Ave. Suite 100A Juneau, AK 99801
(907) 463-2600

Client Information/Registration

Date: _____ Social Security Number: _____
Name: First _____ Middle _____ Last: _____
Address: _____ City: _____ Zip: _____
Mailing Address: _____
Home Phone: _____ Cell/other phone: _____
Birth date: _____ Marital Status: _____ Race: _____
Employer: _____ Occupation _____
Work Status: Full ___ Part time ___ Retired ___ Student ___
Spouse/Partner's Name: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

Responsible Party (Primary Insurance Holder. If same as above leave blank)

First Name: _____ M.I. _____ Last Name: _____
Address: _____
Home Phone: _____ Birth date: _____ Marital Status: S M D W
Social Security Number: _____ Employer: _____
Occupation: _____
Work Status: Full ___ Part time ___ Retired ___ Student ___

Payment and Insurance Information

Primary Insurance: _____
Address: _____
Phone Number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Other Insurance: _____
Address: _____
Phone number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Assignment of Benefits, Release of Information & Payment Agreement

I understand that payment is due at the time of service unless other arrangements have been made. I understand that Inside Passage Midwifery and Natural Medicine will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to Inside Passage.

I permit Inside Passage to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act)

I agree that I am responsible for full payment on this account.

Client signature: _____ Date: _____
Responsible Party (if different): _____ Date: _____

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INSURANCE AND FINANCIAL INFORMATION

I understand and agree that health and accident insurance are an arrangement between an insurance company and me. I hereby authorize Debbie Gillespie ND to furnish medical information to my insurance carriers concerning this condition. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

As a courtesy, we will bill your insurance company for you. Any amount not covered by your plan will be billed to you monthly. Vitamins and other supplements are not typically covered by insurance. If this naturopathic doctor recommends supplements as part of the treatment plan, you will be responsible for those costs should you choose to purchase them from Inside Passage or elsewhere.

In accordance with State of Alaska Naturopathic Regulations (12 AAC 42.900) please be advised that Deborah Gillespie is a Naturopath licensed by the state of Alaska. She earned her degree at Southwest College of Naturopathic Medicine and Health Sciences, which is accredited by the Council on Naturopathic Medical Education, the accrediting agency for naturopathic colleges and programs in the United States and Canada. She is not covered by malpractice insurance at this time.

Please also be advised that in addition to her Naturopathic practice, Dr. Gillespie is also a midwife. There is a possibility your appointments may need to be rescheduled in event of a labor/birth. Every effort will be made to reach you with as much notice as possible should the situation arise.

If you are unable to make your scheduled appointment, please call to cancel within 24 hours or as soon as possible.

By signing below, I have read and understand this policy.

Signature: _____ Date: _____

Printed Name: _____

Parent or Guardian signature: _____

Pediatric Health History

Child's Name: _____ Date of Birth: _____

Gender: M F Grade in school: _____

Mother's Name: _____

Father's Name: _____

Parents are (circle) Married Separated Divorced Living Together Other _____

Are both parents actively involved in the child's life: _____

Parent Concerns: Reason for visit today and other concerns or questions about your child

Has the child been seen by any other doctor(s) for this complaint? If so who and when

Name of regular pediatrician:

Please list all Surgeries and Hospitalization, including date occurred:

List all medicines (prescription or over the counter) the child is **currently** taking

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

List all medicines (prescription or over the counter) child has taken **in the past**

List all nutritional supplements the child is currently taking (vitamins, herbs, etc.)

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

List any known **allergies** to food, medications, environment or animals

Please check box if child has ever had any of the following:

Anemia	CARDIOVASCULAR	GASTROINTESTINL	NOSE/THROAT
Asthma	Breathing problems	Poor appetite	Difficulty breathing
Bronchitis	Chest pain	Bloody stools	Difficulty swallowing
Chicken Pox	Irregular heart beat	Constipation	Frequent Colds
Hepatitis		Diarrhea	Hoarseness
Measles	EYES	Excessive hunger	Mouth-breathing
Mumps	Crossed or wandering	Excessive thirst	Nosebleeds
Rubella	Eye irritation	Vomiting	Persistent cough
Prematurity	Headaches	Stomach aches	Sinus problems
Rheumatic fever	Vision problems	Colic	Sore throat
Pneumonia		GENITO-URINARY	Strep throat
Sickle Cell Disease	HEARING/SPEECH	Bed wetting	Tonsil infections
Whooping cough	Difficulty hearing	Blood in urine	Wheezing
Jaundice	Earache	Diaper rash, persistent	
GENERAL	Ear infections	Discharge from vagina or penis	SKIN
Hyperactivity	Hoarseness	Frequent urination	Rash
Depression	Speech problems	Painful urination	Hives
Dizziness		Unusual urine odor	Itching
Fainting	DENTAL		Scars
Headache	Bleeding gums	MUSCLE/BONE/JOINT	Bruise Easily
Fears/phobias	Grinding teeth	Broken bones or sprains	Eczema
Mood Swings	Cavities/decay	Coordination problems	Cradle Cap
Weight gain/loss	Thumb sucking	Posture problems	OTHER
Tiredness	Last check up? _____	Pain, weakness, swelling	
Nightmares		Growing pains	

Vaccination History

Y = yes, has had; N = no has not had; S = some, did not finish series

Hepatitis B	Y N S	MMR (Measles Mumps Rubella)	Y N S
Rotavirus	Y N S	Varicella (Chicken Pox)	Y N S
DPT (diphtheria, pertussis, tetanus)	Y N S	Hepatitis A	Y N S
Hib (Haemophilus influenza type b)	Y N S	Influenza (yearly flu shot)	Y N S
PCV (Pneumococcal)	Y N S	Meningiococcal	Y N S
IPV (Inactivated Polio Virus)	Y N S	HPV (Gardasil)	Y N S

Any reactions to vaccines? _____

Dietary Assessment

How often does your child eat the following:

	3 or more times a day	Daily	Weekly	Monthly
Beans				
Breads, cereals, grains				
Candy				
Soda				
Eggs				
Meats				
Poultry				
Fish				
Dairy products				
Fruit				
Vegetables				

Family History

Age General Health Age General Health
 Father: _____ Sibling: _____
 Mother: _____ Sibling: _____
 Have any of your children died? yes no Sibling: _____

Please check condition(s) that any of the child's blood relatives (including parents and siblings) have had and the relationship to the child

Condition	Relationship	Condition	Relationship
Alcoholism		Kidney disease	
Allergies		Lung disease	
Arthritis		Mental disease	
Asthma		Muscle disorder	
Bone/joint disorders		Rheumatic fever	
Cancer		Skin disease	
Diabetes		Stroke	
Epilepsy		Thyroid disease	
Genetic defects		Tuberculosis	
Heart disease		Venereal disease	
High blood pressure		Other	

Pre-Natal and Infant Health History

Place of birth: _____ Mother's age at birth: _____

During the pregnancy which conditions did the child's mother have? Check all that apply:

Alcohol use	Exposure to chemicals or radiation
Anemia	Urinary tract infection
Diabetes	Pre-term labor
Non-prescription drug (list)	Sexually transmitted disease
Prescription drugs (list)	High blood pressure
Drug use, recreational (list)	Physical trauma
Tobacco use	Emotional trauma
Edema (swelling)	Other

Describe delivery: on time, premature, late, natural labor, induction, prolonged labor, birth trauma, C-section

Infant Health and Problems:

Birth weight: _____ Length: _____

Birth defects _____
 Breathing problems _____
 Infection _____
 Jaundice _____
 Blood sugar problems _____
 Transfusion _____
 Other _____

Infant Feeding:

Breast fed (if yes for how long) _____

Formula fed (if yes what type and how long) _____

Food introduction: at what age, what foods and any reactions

Developmental and Social History:

Please explain any problems or concerns you have about your child in any of the following areas:

Developmental delay:

Appearance/Weight/Height:

Behavior:

Learning ability/grades:

Sexuality:

Any particular stressors or traumas the child has experienced or witnessed:

Has the child lived near any refinery, polluted area or in a home with lead paint? If so, what sort of pollution was the child exposed to? _____

Has the child ever lived in a house that had new carpeting, paint, or other refurbishing that seemed to affect their health? _____

Does the child seem sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home?

How many hours per day does your child watch television? _____

Does your child play video games? If so how many hours per day? _____

Does your child get exercise on a daily basis? What type?

Thank you for taking the time and effort to complete these forms. I look forward to providing you and your child with the best possible care. If there is anything else you would like to add at this time please do so here or on the back of this form.
