Dr. Rudy Byron, Jr. M.D.
6232 Bankers Road
Mt. Pleasant, WI 53403
262-672-6393

Welcome To Our Office!

Name: _____ Today's Date: _____/_____/_____
First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Email Address: _____ May we contact you here? (circle) YES / NO

Birthdate: _____/_____/_____ Age: _____

Employer: _____ May we contact you at work? (circle) YES / NO

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: ( ) _____-_____ Years employed: _____ Occupation: _____

Name of Spouse: _____

Birthdate: _____/_____/_____ Age: _____

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Email Address: _____ May we contact you here? (circle) YES / NO

Birthdate: _____/_____/_____ Age: _____

Employer: _____ May we contact you at work? (circle) YES / NO

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: ( ) _____-_____ Years employed: _____ Occupation: _____

Do you wish correspondence to be confidential? (circle) YES / NO Do you wish phone calls to be confidential? (circle) YES / NO

How did you hear about Byron Health & Healing? _____

Family Practice New Patient Intake Form

Reason for Visit: _____

Past Medical History:

Please review the list below and check any problems you have had now or in the past:

Abnormal Pap Smear		Eczema		Osteopenia	
Acne		Emphysema		Osteoporosis	
ADD / ADHD		Frequent UTI's		Positive TB Skin Test	
Alcohol abuse		Frequent Sinus Infections		Prostate Problems	
Anemia		Gallstones		Psoriasis	
Anxiety Disorder		Glaucoma		Reflux (heartburn)	
Asthma		Gout		Rheumatoid Arthritis	
Bipolar Disorder		Heart Attack		Rosacea	
Blood Clot		Heart Condition (specify)		Seasonal Allergies	
Blood Transfusion		Hepatitis (specify A,B,C)		Seizures	
Cancer (What kind?)		High Blood Pressure		Sexually Transmitted Disease (specify)	
Chronic Bronchitis		High Cholesterol			
Crohn's Disease or IBS		Kidney Disease		Stomach Ulcers	
Colon Polyps		Kidney Infections		Stroke	
Depression		Kidney Stones		Tuberculosis	
Diabetes		Lupus		Thyroid Disease	
Diverticulitis		Melanoma or Skin Cancer		Ulcerative Colitis	
Drug Abuse		Migraines		Warts	
Eating Disorder		Osteoarthritis			

Other medical problem not on list: _____

Please check or list all **SURGERIES** you have had:

	Type of Surgery	Year
	Appendectomy	
	Arthroscopy (joint)	
	Back or Neck Surgery	
	Cataract Surgery	
	Cesarean Section	
	Gallbladder Removal	
	Heart Surgery (specify)	
	Hemorrhoids	
	Hernia	

	Type of Surgery	Year
	Hysterectomy	
	Knee or Hip Replacement	
	Mastectomy or Lumpectomy	
	Polyp Removal (colon)	
	Tonsillectomy/ Adenoidectomy	
	Tubal Ligation or Vasectomy	
	Plastic Surgery (specify)	
	Other (specify)	

Current Medications: (Please include over the counter medications and food supplements.)

Drug Name:	Dose:	How Often?

Drug Name:	Dose:	How Often?

Are you **ALLERGIC** to any medications? **Yes / No**

Drug Name:	Reaction:

For Women:

Last menstrual period	/ /
Last pap smear n/a	/ /
Last mammogram n/a	/ /
Last bone density	/ /

Age of first period	
# of days in cycle	
# of days in flow	
Are you menopausal	Y N
Age at onset of menopause	

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

Family History: Have any of your family members had any of the following problems?

X	Condition:	Family member:
	Heart Disease / Attack	
	Stroke	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid Disease	
	Depression	
	Other Mental Illness	
	Alcoholism	
	Asthma	

X	Condition:	Family member:
	Osteoporosis	
	Migraines	
	Breast Cancer	
	Colon Cancer	
	Prostate Cancer	
	Lung Cancer	
	Ovarian Cancer	
	Uterine Cancer	
	Skin Cancer	
	Other Cancer (specify)	

Any other illness in the family not listed? _____

Social History:

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Highest Level of Education: 6th ☐ grade ☐ Jr. High ☐ High School ☐ College

☐ Graduate School ☐ Professional

Occupation: _____

If you have children, please list their names and ages:

_____

Health Habits:

1. Do you currently smoke? ☐ Yes ☐ No If so, how much? ____ cig/day
   # of years smoking ____

   If no, did you smoke in the past? ☐ Yes ☐ No How many years? ____

   How much? ___ pk/day

   Quit date _____

   Are you exposed to smoke? Yes ☐ ☐ No

   Any other tobacco use? Yes ☐ ☐ No Type: ☐ Cigars ☐ Chewing tobacco ☐ Snuff ☐ Other

2. Do you drink caffeine? ☐ Yes ☐ No If so, how much? _____
3. Do you drink Alcohol? ☐ Yes ☐ No If so, what kind? ☐ Beer ☐ Wine ☐ Liquor
   How many times? ___ week ___ month ___ year(s)

   Have you ever had a problem with alcohol in the past? (legal or social) ☐ Yes ☐ No

Have you ever used street drugs? ☐ Yes ☐ No

Which ones? ☐ Marijuana ☐ IV drugs ☐ Amphetamines ☐ Cocaine ☐ Heroin ☐ Downers ☐ Inhalants ☐ Other _____

Are you still using? ☐ Yes ☐ No

5. Are you sexually active? (in the last year) ☐ Yes ☐ No
   If yes, check all that apply ☐ 1 partner Multiple partners
   ☐ Male partner(s) Female partner(s)

Which birth control do you or your partner use? ☐ None ☐ Condoms ☐ The Pill ☐ Vasectomy / Tubal ☐ Other _____

6. Do you exercise? ☐ Yes ☐ No If so, what type and how often? _____
7. Do you eat out at restaurants weekly? ☐ Yes ☐ No Times per week _____
8. How many servings of fruits and vegetables do you get per day? 0 1 2 3 4 5 more than 5
9. Do you take a calcium supplement? ☐ Yes ☐ No

   Number of dairy servings per day: _____

10. Do you wear a seatbelt? ☐ Yes ☐ No
11. Do you have a living will? (do not resuscitate, medical power of attorney) ☐ Yes ☐ No Please ask for info.
12. Is there concern for your safety? (emotional, physical, or sexual abuse) ☐ Yes ☐ No

NAME: _____

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Insurance Information

Name: _____ Today's Date: _____
First Middle Last

Primary Insurance

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____

Group Number: _____ Policy ID Number: _____

Secondary Insurance

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____

Group Number: _____ Policy ID Number: _____

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Patient Medication Sheet

Patient Name: _____ Date of Birth: _____

PLEASE INCLUDE ALL MEDICATIONS INCLUDING SUPPLEMENTS:

MEDICATION	DATE PRESCRIBED	DOSAGE	ROUTE	FREQUENCY

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Medical Information Release and Health Information Privacy Notice Form

(*HIPPA RELEASE FORM*)

Patient Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:
[ ] Spouse: _____
[ ] Child(ren): _____
[ ] Other: _____
[ ] Information is not to be released to anyone.

This notice is effective as of the date signed. This authorization will expire seven years after the date on which you last received services from the clinic.

Messages

Our office does like to confirm your reserved time prior to your appointment day. We may occasionally need to leave a voicemail message or leave a message with a family member for you to call our office. Our office also uses an online communication portal called Hello Health for secure messaging.

Please indicate your communication preference below:
Please call: ☐ Home ☐ Work ☐ Cell Contact #_____

☐ Email: _____

If you are unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ Other: _____

The best time of day to reach me is *(day)*_____ between *(time)*_____

Signed: _____ Date: _____

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Acknowledgment of Receipt of Privacy Practices

I, _____ have
(Please print patient's full name)

received a copy of this office's Notice of Privacy Practices (available in our office or on our website on the New Patient Page).

_____ _____
Signature of Patient or Parent/Guardian (if patient is a minor) Date

_____ _____
Witness Date

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Appointment Cancellation Policy Agreement

Patient name: _____

Please call us at (262) 672-6393 by 2:00pm two days (48 hours) **prior to your scheduled appointment** to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00pm on Wednesday. **If the 48-hour prior notification is not given, we must apply a $200.00 charge for the missed appointment.**

Byron Health and Healing is committed to providing all patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please sign below to consent to these terms.

X_____

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Receipt of Patient Guide

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Byron Health and Healing Center Office Policies & Procedures for Patients form.

Printed Name: _____

Signed: _____ Date: _____

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Integrative Treatment Acknowledgment Form

I understand that the evaluation, diagnosis and treatment at Byron Health and Healing includes but is not limited to history visits, physical examinations, common diagnostic procedures, dietary advice, over the counter medications, prescriptions to be filled at a pharmacy, and supplements.

By signing below, I, _____have received, reviewed, understand, and accept this course of treatment
(print name here)

and acknowledge there is no guarantee regarding this course of treatment for my present condition or any future condition.

Signature: _____ Date: _____

Thank you! We look forward to assisting you on your journey to health and wellness!