



## Demographic & Insurance Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Phone (2): \_\_\_\_\_

Marital Status: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Address: \_\_\_\_\_

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

Tranquil Healing Center, PS requires that ***all*** insurance coverage be pre-verified (3 business days) prior to providing insurance billing service for you. A \$3.00 insurance billing fee will be charged per visit in addition to any co-pays, co-insurances, or other fees to provide this service for you. If verification has not been completed ahead of your appointment time, we will provide documentation of your visit to submit to your insurance company and waive the insurance billing fee.

### Insurance Information (primary)

Insurance Name: \_\_\_\_\_

Subscriber #: \_\_\_\_\_

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

Plan Name: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ SSN of Primary: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

### Insurance Information (secondary)

Insurance Name: \_\_\_\_\_

Subscriber #: \_\_\_\_\_

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

Plan Name: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ SSN of Primary: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Guarantor (person who is financially responsible):**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F other

Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

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

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

**Financial Responsibility Agreement**

*Please initial each statement on the line provided in addition to signing and dating on the lines at the bottom of the page.*

**I understand and agree to the following general responsibilities:**

- I am responsible as the patient or patient 's guarantor for full payment of services rendered at the time of service, including office visit fee, in-office lab test or procedures, medications administered, send-out labs, outstanding balances from previous visits/ services, and the \$3.00 insurance billing fee (if Tranquil Healing Center,PS is billing your insurance ) . \_\_\_\_\_
- I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving. \_\_\_\_\_
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Tranquil Healing Center to release information necessary to secure payment. \_\_\_\_\_
- I am financially responsible for a flat fee of \$30 for any appointment not cancelled within 24 hours of the appointment time and date, and will keep an up to date credit or check card on file to fulfill this responsibility. \_\_\_\_\_

**I understand and agree to the following with regards to insurance billing:**

- The pre-verification by Tranquil Healing Center, PS of my insurance benefits is used to determine if there is coverage for services through my insurance carrier and is NOT a guarantee of payment by my insurance carrier. \_\_\_\_\_
- I understand that Tranquil Healing Center, PS can require presentation of proof of insurance at any time. \_\_\_\_\_
- I understand that my insurance may need to be re-verified for specific coverage details as often as every six months. \_\_\_\_\_
- I am responsible for providing all accurate and thorough documentation required to verify my insurance coverage and / or bill my insurance carrier. \_\_\_\_\_
- I am responsible for full and timely payment of all insurance co-pays, deductibles, and co-insurance balances due, including any and all services not covered or paid by my insurance carrier. \_\_\_\_\_
- I forfeit the privilege of billing my insurance carrier if I do not comply with any of my financial responsibilities or documentation requirements. \_\_\_\_\_

I authorize release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to the Tranquil Healing Center, PS and Dr. Terra Sowinski. This release applies to support of the insurance billing process only, records will not be released for any other reason without written consent of the patient. \_\_\_\_\_

**I have fully read and understand the above statements of financial responsibility, and by signing below, agree to abide by and authorize the actions stated there in.**

Printed Name: \_\_\_\_\_  
(patient 18yo or older)

Guarantor Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Guarantor Signature: \_\_\_\_\_

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

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

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

 Drug Allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Medications**

*Please itemize all medications you are currently using or have used recently .  
 Please be sure to include all over the counter medications and hormones.*

Drug Name	Reason for Use	Dose	How Long?	Prescriber

**Current Supplements**

*Please list all vitamins. Minerals herbs, and other natural products you are currently using or have used recently*

Product Name	Reason for Use	Dose	How Long?	Prescriber

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Wt. 1 year ago: \_\_\_\_\_ Max Wt. \_\_\_\_\_

What health concerns would you like Dr. Terra to help you with? : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Rate your commitment: level to your health. How long do you think it will take you to get

Low 1 2 3 4 5 6 7 8 9 10 High well? Why? \_\_\_\_\_

\_\_\_\_\_

**Early Health History**

Did your mother have problems during her pregnancy with you? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Were you:  breast fed? \_\_\_\_\_ mo / yr  bottle fed? \_\_\_\_\_ mo / yr

Please check if you have had any of the following childhood illnesses:

frequent ear infections  colic  eczema  recurrent colds

bronchitis  pneumonia  meningitis  other

Were you on frequent or prolonged antibiotic therapy?  Yes  No

**Immunizations**

I have chosen not to be vaccinated

Did you receive standard immunizations?  Yes  No

***Please provide a copy of your immunization record.***

Did you experience any adverse reactions from immunizations?  Yes  No

If yes, what was the reaction? \_\_\_\_\_

Do you receive a regular influenza vaccination?  Yes  No

Do you have any additional immunizations? (if yes, please list)  Yes  No

\_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### Health Procedures:

*Please check if you have had the following health maintenance procedures within the last 5 years, and please provide dates.*

- |  |             |                 |  |
|--|-------------|-----------------|--|
| <input type="checkbox"/> Full Physical Exam      | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> Dental Exam             | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> Cholesterol Check       | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> CBC, Chemistry, thyroid | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> Colonoscopy:            | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> Eye Exam:               | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> EKG:                    | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> DEXA (bone density):    | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> PAP (f) / Prostate (m): | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> Mammo/ thermogram:      | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> Other: _____            | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> Other: _____            | date: _____ | Findings? _____ |  |
| <input type="checkbox"/> Other: _____            | date: _____ | Findings? _____ |  |

### Surgeries

Date	Procedure	Reason	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Hospitalizations

Date	Reason	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### Review of Systems

*Please Circle all that apply.*

**Y** = present condition      **N** = never had the condition      **P** = past problem      **F** = Family member

#### General

Dizziness      Y N P F      Night Sweats      Y N P F      Fatigue      Y N P F

#### Head:

Headaches      Y N P F      Migraines      Y N P F      Jaw/ TMJ      Y N P F      Vision      Y N P F  
 Hearing      Y N P F      Smelling      Y N P F      Tasting      Y N P F      Dental      Y N P F

#### Skin

Rashes      Y N P F      Eczema, hives      Y N P F      Color Changes      Y N P F      Moles      Y N P F  
 Skin Cancers      Y N P F

#### Musculoskeletal

Joint pain      Y N P F      Muscle spasm      Y N P F      Weakness      Y N P F      Breaks/ Sprains      Y N P F

#### Neurologic

Fainting      Y N P F      Numb/ tingling      Y N P F      Weak muscles      Y N P F      Seizures      Y N P F  
 Paralysis      Y N P F      Loss of memory      Y N P F      Neuropathy      Y N P F

#### Emotional

Mood swings      Y N P F      Nervousness      Y N P F      Tension/ stress      Y N P F      Anxiety      Y N P F  
 Depression      Y N P F

#### Endocrine

Excessive Thirst      Y N P F      Cold intolerance      Y N P F      Thyroid issues      Y N P F      Diabetes      Y N P F  
 Excessive hunger      Y N P F      Heat intolerance      Y N P F

#### Cardiovascular / Respiratory

Cough      Y N P F      Short of Breath      Y N P F      Asthma      Y N P F      Chest Pain      Y N P F  
 Abdominal pain      Y N P F      Blood clots      Y N P F      Heart disease      Y N P F      Low / high BP      Y N P F

#### Gastrointestinal

Diarrhea      Y N P F      Constipation      Y N P F      Abdominal pain      Y N P F      Blood in stool      Y N P F  
 Nausea / Vomiting      Y N P F      BM per day      \_\_\_\_\_

#### Urinary

Incontinence      Y N P F      Infections      Y N P F      Painful urination      Y N P F      Stones      Y N P F

#### Males

Hernias      Y N P F      Testicular mass      Y N P F      Sexual difficulty      Y N P      Trauma / injury      Y N P

#### Female

Age of 1st Menses \_\_\_\_\_      Age last Menses \_\_\_\_\_      Length of Cycle \_\_\_\_\_      Duration Bleeding \_\_\_\_\_  
 Number of Pregnancies \_\_\_\_\_      Number of live Births \_\_\_\_\_      Number of Miscarriages \_\_\_\_\_      Number of Abortions \_\_\_\_\_  
 Birth Control      Y N P      If yes, what type? \_\_\_\_\_      How long? \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Lifestyle Habits***Please provide the following information:*Do you smoke?  yes  no Have you ever?  yes  no

If yes, Packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Smoker in your household?  yes  noDo you use recreational drugs?  yes  no If yes, please list: \_\_\_\_\_Former drug use?  yes  no If yes, please list: \_\_\_\_\_Alcohol Use:  none Type: \_\_\_\_\_ Amount/ frequency: \_\_\_\_\_Job: \_\_\_\_\_ Satisfaction:  Excellent  Good  Fair  Poor

Vacation Frequency: # per year \_\_\_\_\_ Travel frequency: # per year \_\_\_\_\_

Do you have occupational health risks?  yes  no

If yes, please list: \_\_\_\_\_

Sleep Schedule: Time to bed \_\_\_\_\_ Time to wake \_\_\_\_\_ Naps \_\_\_\_\_

Sleep Quality:  well rested  tired when waking  awake during night sleep in total dark  sleep with some light in the roomHave you experienced physical, emotional, sexual or verbal abuse?  yes  noIs your sex life satisfactory?  yes  no

My stress level is:

Minor  1  2  3  4  5  6  7  8  9  10 Severe

My main stressors in life are: \_\_\_\_\_

I relieve stress by: \_\_\_\_\_

The things I do to support my health are: \_\_\_\_\_

The health obstacles that I have are: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Environmental Sensitivities/ exposures**

Do you have adverse reactions to any of the following:

- Odors:       yes       no      reaction: \_\_\_\_\_
- Smoke:      yes       no      reaction: \_\_\_\_\_
- Soap:        yes       no      reaction: \_\_\_\_\_
- Fumes:      yes       no      reaction: \_\_\_\_\_
- Perfumes:  yes       no      reaction: \_\_\_\_\_
- Dust:        yes       no      reaction: \_\_\_\_\_
- Grasses:    yes       no      reaction: \_\_\_\_\_
- Pollen:      yes       no      reaction: \_\_\_\_\_
- Animals:    yes       no      reaction: \_\_\_\_\_
- Mold:        yes       no      reaction: \_\_\_\_\_

Have you been exposed to chemicals, now or in the past?       yes       no  
 If yes, which ones?: \_\_\_\_\_

Have you been exposed to heavy metals, now or in the past?       yes       no  
 If yes, which ones?: \_\_\_\_\_

Do you have multiple electronic devices in your bedroom?       yes       no

Do you live near power lines or a power substation?       yes       no

**Additional Information**

Please provide any additional information that you would like the doctor to know :

\_\_\_\_\_

\_\_\_\_\_

*By signing below I confirm that the information provided on this form is truthful to the best of my knowledge. I give Tranquil Healing Center, PS and Dr. Terra Sowinski permission to use this information to assist in providing healthcare to me only (or the patient if guardian is signing) and securing payment from my insurance company if requested.*

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_