Print Name_____

TINA MARCANTEL, NMD
NATUROPATHIC PHYSICIAN

201 W. Guadalupe Rd. Suite 202
Gilbert, AZ 85233
Tel: 480-892-0211 Fax: 480-892-0216

PATIENT REGISTRATION and PERSONAL INFORMATION

(Please Print Clearly)

PATIENT'S FULL NAME _____ SEX _____

HOME ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP CODE _____

AGE _____

DATE OF BIRTH _____/_____/_____ PLACE OF BIRTH _____

NAME OF EMPLOYER _____ BUSINESS PHONE_____

CELL PHONE _____ MAY CALL WORK PHONE YES NO

E-MAIL ADDRESS _____

SIGNIFICANT RELATIONSHIP STATUS : (Please circle one that applies)

MARRIED NON-MARRIED PARTNER SINGLE WIDOWED SEPARATED DIVORCED

EMERGENCY CONTACT _____RELATIONSHIP_____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____PHONE _____

HOW DID YOU HEAR OF DR. TINA MARCANTEL?_____

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE, I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES ON THIS ACCOUNT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I UNDERSTAND AND AGREE THAT I WILL PAY A FEE FOR THE DOCTOR'S TIME IF I FAIL TO CANCEL OR RESCHEDULE AN APPOINTMENT WITH LESS THAN 24 HOURS NOTICE.

SIGNATURE _____ DATE _____

Print Name_____

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CONTEXT OF CARE REVIEW

What do you know about our **approach**?

What *three* **expectations** do you have from *this* visit to the clinic?

What *long term* expectations do you have from working with our clinic?

What is your present level of **commitment** to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are **non-beneficial** to your health?

What potential **obstacles** do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently **support** you with the beneficial lifestyle changes you will be making?

What do you **love to do**?

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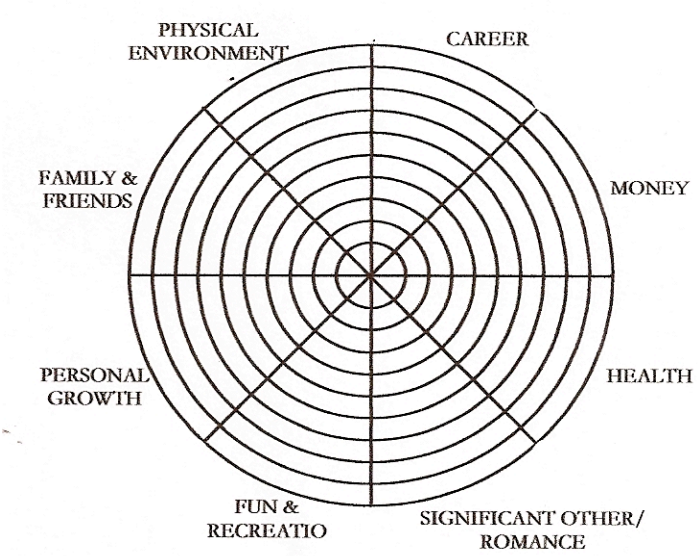
WHEEL OF BALANCE

Wellness is a balance of many factors. Using this circle, shade your level of satisfaction on each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, **starting from the center point radiating outward.**



Are you currently receiving healthcare? Yes / No

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

_____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

Print Name_____

MEDICAL HISTORY: Mark "C" (current) or "P" (past) for any conditions you or your relatives have had.

CONDITION	SELF	MOTHER	FATHER	SIBLING	CHILDREN	GRAND PARENTS
ALCOHOL						
ALLERGIES						
ANEMIA						
ARTHRITIS						
ASTHMA						
BLEEDING PROBLEMS						
CANCER						
DIABETES						
DRUGS						
SKIN CONDITIONS						
EMPHYSEMA						
EPILEPSY						
GOUT						
HEART PROBLEMS						
HEPATITIS						
HIGH BLOOD PRESSURE						
MENOPAUSE						
MENTAL DISORDER						
MIGRAINES						
PERIOD ABNORMALITY						
PMS						
PROSTATE PROBLEMS						
STROKE						
THYROID PROBLEMS						
ULCERS						
VENEREAL DISEASE						
WEIGHT PROBLEMS						

LIST OPERATIONS, MAJOR INJURIES, OR OTHER MEDICAL PROBLEMS – INCLUDE DATE

DATE	PROCEDURE OR EVENT	RESIDUAL/LINGERING EFFECT

Print Name_____

Dx_____

ALLERGIES_____

Preferred pharmacy name & phone number _____

CURRENT PRESCRIPTION MEDICATIONS

START DATE	NAME OF PRESCRIPTION MEDICATION AND REASON FOR USE	DOSAGE

SUPPLEMENTS AND/OR VITAMINS

START DATE	NAME OF SUPPLEMENT AND REASON FOR USE	DOSAGE

Print Name_____

FEMALE Symptom Checklist

LABORATORY TESTING MADE SIMPLE
1-866-600-1636| info@zrtlab.com| www.zrtlab.com
ZRT Laboratory

Use each of the following checklists to determine your symptoms of hormone imbalance and to help you choose the appropriate hormone test profile.

Category 1: Basic Hormone Imbalance

Mark which of the following symptoms are troublesome and/or persist over time.

_____ Hot flashes	_____ Mood swings (PMS)	_____ Urinary incontinence	_____ Night sweats
_____ Heart palpitations	_____ Cystic ovaries	_____ Vaginal dryness	_____ Acne
_____ Heavy menses	_____ Foggy thinking	_____ Weight gain	_____ Depressed mood
_____ Fibrocystic breasts	_____ Irritability	_____ Increased body/facial hair	_____ Headaches
_____ Thinning skin	_____ Uterine fibroids		_____ Bone loss

Category 2: Adrenal Hormone Imbalance

Mark which of the following symptoms are troublesome and/or persist over time.

_____ Aches and pains	_____ Elevated triglycerides	_____ Morning fatigue	_____ Bone loss
_____ Sleep disturbances	_____ Depression	_____ Anxiety	_____ Blood sugar imbalance
_____ Infertility	_____ Nervousness	_____ Allergic conditions	_____ Autoimmune illness
_____ Chronic illness	_____ Evening fatigue	_____ Susceptibility to infections	

Category 3: Thyroid Hormone Imbalance

Mark which of the following symptoms are troublesome and/or persist over time.

_____ Aches and pains	_____ Anxiety	_____ Brittle nails	_____ Depression
_____ Dry skin	_____ Cold hands and feet	_____ Headaches	_____ Infertility
_____ Fatigue	_____ Foggy thinking	_____ Weight gain	_____ Feeling cold all the time
_____ Heart palpitations	_____ Low libido	_____ Inability to lose weight	_____ Sleep disturbances
_____ Constipation	_____ Thinning hair	_____ Menstrual irregularities	_____ Elevated cholesterol

Category 4: Cardiometabolic Risk

Mark which of the following symptoms are troublesome and/or persist over time.

_____ Smoker	_____ Weight gain	_____ Heart disease or family history of heart disease
_____ High blood sugar	_____ Sugar cravings	_____ Diabetes or family history of diabetes
_____ High blood pressure	_____ Fatigue	_____ Waist size greater than 35 inches
_____ Overweight or obese	_____ Low physical activity	

If you checked symptoms in <u>All four categories</u>, the suggested test profiles are:
GOOD: Female Blood Profile I (Blood Spot) or Female/Male Saliva Profile I (Saliva)
BEST: Comprehensive Female Profile I or II (Saliva/Blood Spot) and CardioMetabolic Profile I (Blood)

If you checked symptoms <u>ONLY in Category 1</u>, the suggested test profiles are:
GOOD: Female Blood Profile I (Blood Spot) or Female/Male Saliva Profile I (Saliva)
BEST: Comprehensive Female Profile I or II (Saliva/Blood Spot)

If you checked symptoms <u>ONLY in Category 2</u>, the suggested test profiles are:
GOOD: Diurnal Cortisol (Saliva)
BEST: Comprehensive Female Profile I or II (Saliva/Blood Spot)

If you checked symptoms <u>ONLY in Category 3</u>, the suggested test profiles are:
GOOD: Complete Thyroid Profile (Blood Spot)
BEST: Comprehensive Female Profile I or II (Saliva/Blood Spot)

If you checked symptoms <u>ONLY in Category 4</u>, the suggested test profiles are:
GOOD: CardioMetabolic Profile I (Blood) plus Diurnal Cortisol (Saliva)
BEST: CardioMetabolic Profile I (Blood) plus Female/Male Saliva Profile III (Saliva)

Print Name_____

PATIENT FEES

Cost of services: Initial intake visit (approx. 1 hour): $225.00. Extended initial visit (approx. 90 min.): $335.00. Follow-up visits are typically 15 minutes to 1 hour ($55.00-$195.00). Please ask for specific prices before receiving treatment.

Note: Prices for products and services are subject to change without notice. For a complete listing of our current prices please see our website or ask our receptionist for a price list.

Dr. Tina Marcantel will do **phone consultations for established patients** under special circumstances when an office visit may not be deemed necessary or possible. Fees are dependent on the length of the consultation.

To better monitor the progress of our patients we encourage the use of e-mail correspondence. This **free service** is provided to allow patients to send **brief** updates to Dr. Marcantel regarding symptoms or to seek clarification about treatment. These *e-mail updates are not meant to take the place of an office visit or a phone consultation*; they are a way to help the patient and Dr. Marcantel make the most efficient use of your time together to ensure that you are receiving the best possible treatment we can offer.

CANCELLATION CHARGE
If an appointment is cancelled or rescheduled with a minimum of 24 hours notice, no charge is incurred by the patient. **We do not double book our schedule and your scheduled clinic visit is reserved for you and the doctor.** Cancellations made with less than 24 hours notice may be subject to cancellation fees.

INSURANCE BILLING
Full payment is due at the time of service. As an **additional free service** to our patients, Dr. Marcantel's staff will submit billing claims for reimbursement to most insurance companies. Submission of a claim does not guarantee reimbursement and is subject to your individual health plan benefits. We do not offer prequalification of coverage for patients. Please contact your insurance provider directly with questions about covered services. All insurance reimbursements received by our office will be credited to the patient's account or directly reimbursed to the patient. **Please note: Medicare does not cover Naturopathic Physicians and we are unable to bill Medicare for services.**

DISPENSARY
The clinic maintains a dispensary for your convenience and to ensure that patients may obtain quality products. You may purchase similar or like products elsewhere. If you experience undesirable and out-of-ordinary symptoms after taking a product purchased at our dispensary, please call and let the doctor know immediately. **Unopened** products purchased at the clinic may be returned within 14 days for refund.

INFORMED CONSENT
Your signature below verifies the understanding of the information above and also gives Dr. Tina Marcantel, an Arizona state licensed naturopathic physician, consent for naturopathic treatment for you or the minor for whom you are legally in charge.

PATIENT'S/GUARDIAN'S SIGNATURE _____DATE _____

NAME OF MINOR _____RELATION TO MINOR _____

Dr. Marcantel is committed to providing quality health care. We provide you with an individualized plan because we consider each person a unique individual with unique health needs. Thank you for joining our health team. We look forward to coaching, supporting, and providing you with alternative and integrated health approaches to health care.

Print Name_____

Dr. Tina Marcantel
Gilbert Professional Plaza
201 W. Guadalupe Rd. Ste. 202
Gilbert, AZ 85233
(480) 892-0211

Our office is located near the crossroads of Gilbert and W. Guadalupe Roads in the Gilbert Professional Plaza. We are just WEST of Gilbert Rd. on Guadalupe, behind the Fresh and Easy Market. Our suite is located at the west end of the breezeway between buildings 100 and 200.