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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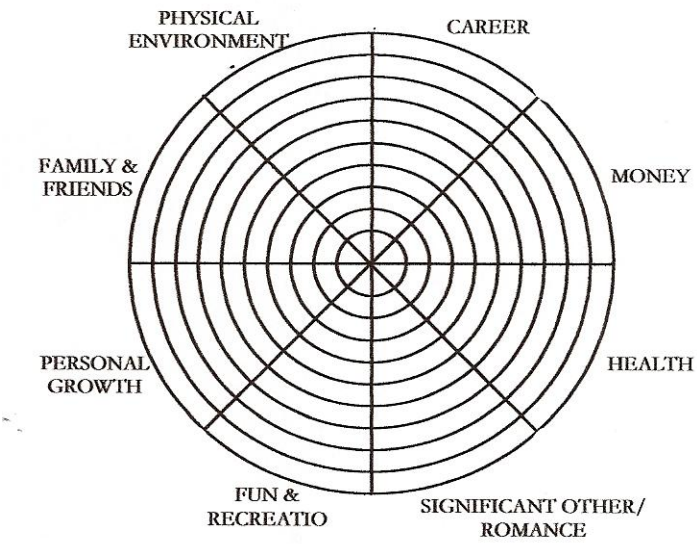
WHEEL OF BALANCE

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_____

MALE 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.

_____ Burned out feeling
_____ Hot flashes
_____ Weight gain waist
_____ Decreased libido
_____ Decreased erections
_____ Night sweats
_____ Irritable
_____ Erectile dysfunction
_____ Prostate problems
_____ Decreased mental sharpness
_____ Insomnia
_____ Increased urinary urge
_____ Infertility problems
_____ Oily skin
_____ Apathy
_____ Decreased urine flow
_____ Decreased stamina
_____ Sleep disturbances
_____ Decreased muscle mass

Category 2: Adrenal Hormone Imbalance

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

_____ Aches and pains
_____ Sleep disturbances
_____ Infertility
_____ Chronic illness
_____ Stress
_____ Elevated triglycerides
_____ Depression
_____ Lack of motivation
_____ Prostate problems
_____ Evening fatigue
_____ Morning fatigue
_____ Anxiety
_____ Allergic conditions
_____ Weight gain waist
_____ Decreased erections
_____ Bone loss
_____ Blood sugar imbalance
_____ Autoimmune illness
_____ Fibromyalgia
_____ Susceptibility to infections

Category 3: Thyroid Hormone Imbalance

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

_____ Low libido
_____ Foggy thinking
_____ Constipation
_____ Elevated cholesterol
_____ Depression
_____ Infertility
_____ Fatigue
_____ Cold body temperature
_____ Headaches
_____ Lack of motivation
_____ Decreased erections
_____ Sleep disturbances
_____ Inability to lose weight

Category 4: Cardiometabolic Risk

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

_____ Smoker
_____ High blood sugar
_____ High blood pressure
_____ Overweight or obese
_____ Weight gain
_____ Sugar cravings
_____ Fatigue
_____ Low physical activity
_____ Heart disease or family history of heart disease
_____ Diabetes or family history of diabetes
_____ Waist size greater than 40 inches

If you checked symptoms in <u>All four categories</u>, the suggested test profiles are:
GOOD: Male Blood Profile I (Blood Spot) or Female/Male Saliva Profile I (Saliva)
BEST: Comprehensive Male 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: Male Blood Profile I (Blood Spot) or Female/Male Saliva Profile I (Saliva)
BEST: Comprehensive Male 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 Male 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 Male 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 48 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 48 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.