Dr. Alyssa DiRienzo, ND

Please find your new patient paperwork attached.

Please be sure to fill out all of the papers as completely as possible, so as not to delay your appointment.

Also, please be sure to bring along your insurance card and any referral you may have.

I strongly advise you to call your member services or eligibility number listed on your insurance card and request your benefit information. While I may be a listed provider on your plan, sometimes plans have special requirements for benefit eligibility. Some plans have different co-payments or variations on basic benefits for naturopathic physicians. It is always best to confirm your benefits.

Please plan to arrive at least 15 minutes early so we can get your paperwork together and checked in for your appointment.

If you are going to be late for an appointment, please call ahead as it may be necessary to reschedule your appointment.

I look forward to meeting with you!

Dr. Alyssa DiRienzo

ALYSSA DIRIENZO N.D. L.L.C.
SAGE MEDICINE

PATIENT REGISTRATION

Please fill out completely

Patient Name: MI: Last:

Street Address:

City: State: Zip:

SSN: Gender: ( )M ( )F Home ph: ( )

Employer / occupation: Work ph: ( )

Date of Birth: / / Age: Alt ph: ( )

Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependant ( )Partnered ( )Other

( )Parent / ( )Guardian / ( )Spouse / ( )Partner: Phone: ( )

Referred by:

In case of emergency contact: Relationship:

Phone: ( )

PRIMARY INSURANCE

Insurance Company Name: Phone: ( )

Claims Address:

City, State, Zip:

Subscriber's Name: Date of Birth: / /

Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other

I.D. # **as shown on card**: Group #:

Employer of insured:

SECONDARY INSURANCE OR AUTO / L & I

Is this visit injury related? ( )Y ( )N Work related? ( )Y ( )N Auto accident? ( )Y ( )N State:_____

Insurance Company Name: Phone: ( )

Claims Address:

City, State, Zip:

Subscriber's Name: Date of Birth: / /

Relationship to you: ( )Self ( )Spouse ( )Dependant ( )Other

I.D./ Claim # **as shown on card**: Policy #:

Employer if applicable: Effective / Injury Date: / /

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assesed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature _____ Date _____

ALYSSA DIRIENZO, N.D., L.L.C.

Health History

Name: _____ Date: _____

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. Please use the back of the page if you need more room to write.

When and where did you last receive medical/health care? _____

What are your most important health problems? (symptoms, diagnosis, duration, etc.)

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

Exercise

Type of Activity:	Days per week:	Length of workout:

Diet: Please enter number per day:

Meals: _____ Snacks: _____ Caffeinated drinks: _____ Alcoholic drinks: _____ Tobacco use: _____

Prescribed Medications

Name	Dose

Vitamins/Supplements/Herbs/Over the Counter Remedies/Recreational drugs

Name	Dose

Name: _____ Date: _____

Your Family Medical History

	Father	Mother	Brother(s)	Sister(s)	Spouse	Child
Age (at death if deceased)						
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐

Your Health History

Accidents or Significant Traumas (physical or emotional)

Date:	Description:

Surgeries, hospitalizations, and/or in-patient treatments

Date:	Description:

Childhood diseases

☐Scarlet fever ☐Diphtheria ☐Measles ☐Mumps ☐Rheumatic fever ☐German measles

Other_____

Immunizations

☐Polio ☐Tetanus ☐MMR ☐Pertussis ☐Diphtheria Other: _____

Name: _____ Date: _____

Your Current Health

Conditions with which you have been diagnosed:

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

All allergies you have to medications or other substances:

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

Place a checkmark next to the conditions you have experienced within the past year:

Skin and Hair

- ☐ Rashes
- ☐ Eczema/Psoriasis
- ☐ Skin color change
- ☐ Dermatitis
- ☐ Ulcerations
- ☐ Dandruff
- ☐ Acne
- ☐ Warts
- ☐ Hives/Allergic Dermatitis
- ☐ Loss of hair
- ☐ Change in skin/hair texture
- ☐ Fungal Infection
- ☐ Itching
- ☐ Moles
- ☐ Face flushing
- ☐ Excessive sweating

Head, Eyes, Ears, Nose and Throat

- ☐ Glasses
- ☐ Eye Strain
- ☐ Glaucoma
- ☐ Eye pain
- ☐ Dryness in eyes
- ☐ Cataracts
- ☐ Night Blindness
- ☐ Blurred/poor vision
- ☐ Spots in front of eyes
- ☐ Double vision
- ☐ Dental/gum problems
- ☐ Sinus problems
- ☐ Difficulty swallowing
- ☐ Frequent sore throats/colds
- ☐ Sores on lips/tongue
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Jaw clicks/locks
- ☐ Headaches
- ☐ Migraines
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Poor hearing
- ☐ Facial pain

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Cold hands/feet
- ☐ Spontaneous sweating
- ☐ Swelling of hands/feet
- ☐ Irregular heart beat
- ☐ Varicose/spider veins
- ☐ Blood clots
- ☐ Angina
- ☐ Fainting
- ☐ High blood pressure
- ☐ Low blood pressure

Respiratory

- ☐ Cough/Wheezing
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Pain with deep inhalation
- ☐ Shortness of breath
- ☐ Difficulty breathing

Name: _____ Date: _____

Gastrointestinal

- ☐ Changes in appetite
- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating/Edema
- ☐ Gas
- ☐ Belching
- ☐ Bad breath
- ☐ Acid reflux
- ☐ Significant thirst
- ☐ Loose stools/diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Black stools
- ☐ Blood in stool
- ☐ Abdominal pain/cramps
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Gall bladder disease
- ☐ Liver disease
- ☐ Ulcers

Genito-Urinary (Male patients)

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Decreased libido
- ☐ Pain in testicles
- ☐ Blood in urine
- ☐ Scanty flow
- ☐ Urinary tract infection
- ☐ Prostatitis
- ☐ Herpes
- ☐ Urgent urination
- ☐ Copious flow
- ☐ Burning urination
- ☐ Dribbling after urination
- ☐ Infections

☐ Night urination... What time?_____ How often?_____

Gynecological-Urinary (Female patients)

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Frequent urination
- ☐ Scanty flow
- ☐ Urinary tract infection
- ☐ Blood in urine
- ☐ Painful intercourse
- ☐ Sores on genitals
- ☐ Vaginal dryness
- ☐ Vaginal discharge
- ☐ Infertility
- ☐ Endometriosis
- ☐ PMS
- ☐ Painful menstruation
- ☐ Irregular menstruation
- ☐ Bleeding between cycles
- ☐ Uterine Fibroids
- ☐ Ovarian cysts
- ☐ Fibrocystic breast tissue
- ☐ Breast lumps
- ☐ Breast pain/tenderness
- ☐ Nipple discharge

Age of first menses: ____ Date of last menses: ____ Number of days of menses: ____ Frequency of menses: ____

Number of live births ____ Number of miscarriages _____ Number of abortions_____ Date of last PAP ____

Do you practice birth control?_____ What type?_____ How long?_____

Musculoskeletal

- ☐ Joint pain/stiffness
- ☐ Muscle pain/cramps
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Back pain
- ☐ Sciatica
- ☐ Sprains/Strains
- ☐ Broken bones

Neuropsychological

- ☐ Seizures/Fainting
- ☐ Alcoholism
- ☐ Addiction
- ☐ Anxiety/Panic attacks
- ☐ Nervousness
- ☐ Tension/stress
- ☐ Bad temper/irritable
- ☐ Seasonal Affective Disorder
- ☐ Depression
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Lack of coordination

Comments:

Please inform me of any other problems you would like to discuss.

_____

_____

_____

_____