902 Santa Fe

902 Santa Fe Avenue, Albany, CA 94706

Tiffany Baer, MD
Internal Medicine, Holistic Medicine
Anthroposophic Medicine

(510) 526-5256 • fax (510) 526-5547
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ADULT HEALTH HISTORY (Confidential)

Please take your time to be thorough and complete all the questions below.

Name:_____ Date: _____

Address:_____ City, State, Zip:_____

Home Phone:_____ Cell:_____ Email:_____

Date of Birth:_____ Age:_____ Sex:_____

Name of Health Insurance (if applicable):_____

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Home Phone:_____ Emergency Cell:_____

Number of children: _____ Age and Sex of Children:_____

_____

Marital Status (circle one): Single Partner Married Separated Divorced Widow(er)

Social History

Birthplace:_____

Places you were raised:_____

_____

Places you have travelled:_____

_____

Have you been outside of the U.S. in the last 12 months? If so, where? :_____

_____

Do you drink alcohol?_____

Do you exercise?_____ How often? _____

Do you maintain a healthy diet? _____ Please Describe_____

_____

_____

Do you consume caffeine? (Soda, coffee, tea, etc.?) _____

How many cups do you consume daily? _____

Do you smoke? _____ If so, how much? _____ Past? _____

Do you use recreational drugs? _____ Past? _____

Current Health Care

Are you currently under the care of any health providers?_____

Please list:

_____

_____

_____

_____

Where and when did you last receive health care?

_____

_____

_____

Please list your health concerns/goals:

_____

_____

Please rate your current status of health (Scale of 1-10: 1=poor 10=optimal):

1 2 3 4 5 6 7 8 9 10

A major source of **joy** in my life is: _____

A major source of **stress** in my life is: _____

Do you fall asleep easily and sleep soundly?_____

Do you awaken in the morning well rested? _____

Do you have the ability to concentrate for extended periods of time? _____

Does your job utilize all of your greatest talents? _____

Do you maintain peace of mind and tranquility?_____

Are you able to express fear?_____Anger?_____Sadness?_____

Do you take the time for prayer, meditation or reflection?_____

Are creative activities a part of your life?_____

Do you feel a sense of purpose?_____

Do you confide in or speak openly with one or more close friends?_____

Do you or did you feel close to your parents?_____

Do you feel a sense of belonging to a group or community?_____

Past Medical History

Were you born by vaginal delivery or C-Section? _____

Were you breast fed?_____

Did child have any childhood illnesses?_____ If so, which ones? _____

Did you have many childhood illnesses? _____ If so, which ones? _____

Did you have any serious injuries or disabilities? _____

Have you been hospitalized?_____

Year:_____Operation or illness:_____

Name of Hospital:_____Location:_____

Year:_____Operation or illness:_____

Name of Hospital:_____Location:_____

Year:_____Operation or illness:_____

Name of Hospital:_____Location:_____

Please list any allergies to medicines:_____

_____

Please list any environmental or food allergies:_____

_____

Sexual History

Are you sexually active? _____

Contraceptive method used by your or your partner: _____

Your partners are (circle one): Male Female Both

WOMEN

Number of:

Pregnancies:_____ Abortions:_____ Miscarriages:_____

Date of last menses:_____ Number of days in cycle:_____

Medications

Please list all medications:

Medication	Dose	Date Started	Prescribed By

List every vitamin, supplement, or homeopathic remedy you take:

Supplement	Dose	Date Started

Family History

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Grandparents _____

Immunization and Test History

Please list the dates of your latest immunizations/tests:

	Date		Date		Date
Tetanus		Sigmoidoscopy		Chest Xray	
Polio		Blood in stool		EKG	
Rubella		TB Skin test		Mammogram	
Mumps		Physical Exam		PAP Smear	
Measles		Flu Shot		Colonoscopy	
Hepatitis		Pneumonia Shot		Other:	

Problem Summary

Current Problem:_____

_____

_____

_____

Chronic Problem:_____

_____

_____

_____

Recurring Problem:_____

_____

_____

_____

Finances

Payment for services are due at the time of visit in the form of cash or check. If payment on the day of your visit is a concern, please speak to Dr. Baer prior to your appointment.

If you have health insurance coverage, we will provide you with a coded receipt (superbill) to send to your insurance company.

We do not provide insurance billing and I do not take Medicare/Medical/Worker's Comp.

Remedies

Remedies are not included in the cost of your office visit. After agreeing to your treatment plan, you will be responsible for the cost of your remedies. Please inform Dr. Baer when you are down to a quarter left of your remedy so she can order a refill, if necessary.

Appointments

Please give 48 hours' notice if you wish to cancel or reschedule.
There will be a 50% charge for the visit if cancelled with less than 24 hours' notice.

When to contact your PCP:

- For standard office procedures, vaccinations, general check-ups (pap smears, mammograms, etc.)
- For urgent care matters, after-hours visits, or on-call physician access
- For refills on your regular prescriptions that are being managed by your PCP

Fees:

New Patients

Limited (30 Minutes)	$140.00
Comprehensive (1 Hour)	$280.00
Complex (2 hours)	$340.00
Medical Exemption	$280.00

Follow Up Appointment

Brief (15 Minutes)	$70.00
Limited (30 Minutes)	$140.00
Comprehensive (1 Hour)	$280.00

Phone consultations:

The first 5-10 minutes of a phone consultation is without charge. After this time, you will be charged according to the above fee schedule.

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CONSENT FOR TREATMENT

I hereby consent to a comprehensive medical treatment. This means that I am seeking treatment beyond conventional therapy. Conventional or allopathic medicine is based on physical findings and diagnosis, and uses chemical substances (pharmaceutical drugs), surgery, and radiation therapy.
I am responsible for the choice to seek a therapeutic regimen that is individualized and may include physical, physiological, environmental, emotional, mental, and spiritual aspects.
I recognize that this treatment may not prove effective.
I am fully informed that this therapy differs from conventional medical standards. I recognize that this treatment – like any other medical treatment – can have side effects, such as homeopathic aggravations in sensitive patients.
I fully understand that this is given in advance of any specific diagnosis or treatment. I intend to consent to be continuing in nature even after a specific diagnosis had been made and treatment recommended. The consent will remain in full force until revoked in writing.

I am also aware that as a consulting physician specializing in Anthroposophical medicine, Tiffany Baer, M.D., is not available on nights, weekends, and/or specific holidays throughout the year and she does not admit patients to hospitals. In addition to being a patient of Dr. Baer's, I understand that it would be in my best interest to have a Primary Care Physician (PCP) with hospital and admitting privileges that could provide emergency care. I also understand that I may elect to use a hospital emergency room for emergency care, if needed, if I choose not to have another Primary Care Physician.

Patient Name:_____ Date:_____

Signature: _____

Parent/ Guardian name: _____

Parent/Guardian Signature:_____

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize Dr. Tiffany Baer to release information on

_____(Patient's Name) _____ (Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____
Name

_____
Address

_____ _____ _____
City State Zip Code

The medical information/records will be used for the following purpose:

_____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information:

_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)

Psychiatric/Mental Health _____(initial)

Tests for Antibodies to HIV _____(initial)

HIV Diagnosis/Treatment _____(initial)

Genetic Information _____(initial)

DURATION

This authorization shall be effective immediately and remain in effect until _____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____

Signature of patient *or legal/personal representative patient* | Relationship *if other than representative*

_____ _____

Patient's Name (PRINT) | Date

_____ _____

Patient's Social Security Number | Patient's Date of Birth

_____ _____

Witness name | Witness signature

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HIPPA NOTICE OF PRIVACY PRACTICE - ACKNOWLEGEMENT OF RECEIPT

I hereby acknowledge that a current copy of the medical practice's Notice of Privacy Practices is available online at www.hhs.gov/hipaa as well as in the reception area.

Today's Date: _____

Patient Name: _____

Patient/Guardian Signature: _____ _____
Date

_____
(Print Name of Guardian if signing for patient)

If not signed by the patient, please indicate relationship:

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient

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MEDICARE BENEFICIARY AGREEMENT

I, _____ Medicare beneficiary, clearly understand that by signing this contract, I will:

1. Agree not to submit a claim (for such items or services, even if such items or services are otherwise covered by Medicare).

2. Agree to be responsible, whether through insurance or otherwise, for payment of such items or services, and understand that no reimbursement will be provided for such items or services by Medicare.

3. Acknowledge that no limits apply to amounts that may be charged for such items or services.

4. Acknowledge that Medigap plans do not, and other supplemental plans may elect not to make payments for such items or services, because payment is not made with Medicare.

5. Acknowledge that, as a Medicare beneficiary, I have the right to such items and services provided by other physicians or practitioners, for whom payment would be made under Medicare.

Patient/Guardian Signature: _____ _____
Date

_____
(Print Name of Patient/Guardian)