Marcey Shapiro, MD
HOLISTIC FAMILY MEDICINE
office@MarceyShapiroMD.com

P.O. Box 247
Embudo, NM 87531

Phone: 510-525-2200
Fax: 510-526-9648

CONFIDENTIAL

PERSONAL INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____
Address: _____ Occupation: _____
_____ Employed by: _____
Home Phone: _____ Work/Cell Phone: _____
Email: _____
Emergency Contact: _____ Relationship: _____ Emergency Phone: _____
Health Insurance: _____
Who referred you to this clinic? _____

SOCIAL HISTORY

Birthplace: _____ Places you were raised: _____
A major source of **JOY** in my life is: _____
A major source of **STRESS** in my life is: _____
Have you been outside the U.S. in the past 12 months? _____ Where? _____
Do you have a regular exercise program? _____ Please explain: _____
_____
List all leisure activities: _____
_____
_____
How many sodas do you drink daily? _____ How many cups of coffee or black tea do you drink daily? _____
Do you smoke? _____ If yes, list average amount per day (*i.e. # of cigarettes or packs*): _____
Did you quit smoking? _____ Year quit: _____ How long did you smoke and how much? _____
Do you drink alcohol? _____ How often? _____ Amount consumed: _____
Other relevant social habits/ issues: _____
_____

FAMILY HEALTH HISTORY

	Age	**State of Health**	**Past / Present Illnesses**
MOTHER	_____	_____	_____
FATHER	_____	_____	_____
SIBLING(S) (*List below.*)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
SPOUSE/PARTNER:	_____	_____	_____
CHILDREN (*List below.*)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Circle the following if any blood relative has had this condition, past or present. Circle all that apply.

☐ Alcoholism	☐ Cancer, Breast	☐ Epilepsy	☐ Liver Disease
☐ Allergies	☐ Cancer, Colon	☐ Hereditary Disease	☐ Thyroid Disease
☐ Anemia	☐ Cancer, Other _____	☐ Heart Disease	☐ Tuberculosis
☐ Asthma	☐ _____	☐ High Blood Pressure	☐ Mental Condition
☐ Arthritis	☐ Diabetes	☐ Kidney Disease / Stone	☐ Glaucoma / Cataract
☐ Bleeding Tendency	☐ Drug problem	☐ Other _____	☐ Other _____

PERSONAL HEALTH HISTORY

Illness History:

Circle the following if you have had this condition, past or present. Circle all that apply to you.

☐ Alcoholism	☐ Chicken Pox	☐ Eye Infection	☐ Kidney Disease / Stone	☐ Peptic Ulcer
☐ Allergies	☐ Chronic Headache	☐ Glaucoma / Cataract	☐ Liver Disease	☐ Pneumonia
☐ Asthma	☐ Chronic Heartburn	☐ Hay Fever	☐ Lung Disease	☐ Polio
☐ Anemia	☐ Colitis	☐ Heart Disease	☐ Malaria	☐ Rheumatism
☐ Anxiety / Tension	☐ Depression	☐ Hepatitis A, B or C	☐ Measles	☐ Rubella
☐ Arthritis	☐ Diabetes	☐ Hemorrhoids	☐ Mental Condition	☐ Scarlet Fever
☐ Bleeding Tendency	☐ Diverticulitis	☐ Hereditary Disease	☐ Mononucleosis	☐ Skin Problems
☐ Blood Transfusion	☐ Drug Problem / Abuse	☐ Hernia	☐ Mumps	☐ Thyroid Disease
☐ Bronchitis	☐ Eczema	☐ High Blood Pressure	☐ Nervous Condition	☐ Tuberculosis
☐ Cancer, Breast	☐ Emphysema	☐ Hives / Rashes	☐ Neuralgia / Neuritis	☐ Yellow Jaundice
☐ Cancer, Colon	☐ Epilepsy / Convulsion	☐ Hyperactivity	☐ Osteoporosis	
☐ Cancer, Other: _____		☐ Kidney Infection	☐ Pancreatitis	

Please list any other illnesses past or present: _____

_____

Please list any serious injuries or disabilities: _____

_____

Please list any known allergies to medications: _____

_____

Please list all other known allergies: _____

_____

Sexual History:

Are you sexually active? Yes / No (*Circle which applies. Your response is optional and will be kept confidential.*)
Your partner(s) are: Male / Female / Both (*Circle which applies.*)
Contraceptive method used by you and/or your partner(s): _____
Please list any sexually transmitted infection(s), past or present: _____

_____

Hospitalizations:

Year	**Reason for Hospitalization (Operation, Illness, etc.)**	**Hospital Name & Location**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations and Tests:

	Date		**Date**		**Date**
Tetanus	_____	Chest X-ray	_____	Sigmoidoscopy	_____
Oral Polio	_____	EKG	_____	Stool Blood Test	_____
Rubella	_____	Mammogram	_____	TB Skin Test	_____
Mumps	_____	Pap Smear	_____	Complete Physical	_____
Measles	_____	GI Series	_____	Flu Shot	_____
Hepatitis	_____	Other: _____		Pneumonia Shot	_____

FOR WOMEN

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

Pregnancies:

Date	**Your Age**

Children:

Name	**Date of Birth**

Miscarriages:

Date	**Your Age**

Abortions:

Date	**Your Age**

ANYTHING ELSE

Please use the space below to share anything else you would like Dr. Shapiro to know about you.

Using check marks please indicate if you have recently experienced any of the following:

1 one check mark = occasionally 2 check marks = Regularly 3 check marks = Extreme

Head and Neck
- ☐ headaches
- ☐ neck pain
- ☐ neck lumps & swelling

Eyes
- ☐ wears glasses
- ☐ blurry vision
- ☐ eyesight worsening
- ☐ see double
- ☐ see a halo
- ☐ eye pain
- ☐ watering eyes

Ears
- ☐ hearing difficulties
- ☐ earaches
- ☐ ear wax
- ☐ buzzing in ears
- ☐ motion sickness

Mouth
- ☐ dental problems
- ☐ swelling on gum or jaw
- ☐ sore tongue
- ☐ taste changes

Nose and Throat
- ☐ congested nose
- ☐ running nose
- ☐ sneezing spells
- ☐ head colds
- ☐ nose bleeds
- ☐ sore throat
- ☐ enlarged tonsils
- ☐ hoarse voice

Respiratory
- ☐ wheezing
- ☐ coughing spells
- ☐ coughing up phlegm
- ☐ coughing up blood ___
- ☐ st colds
- ☐ night sweats

Cardiovascular
- ☐ high blood pressure ___
- ☐ ing heart
- ☐ chest pains
- ☐ dizzy spells
- ☐ shortness of breath ___
- ☐ ath shortness at night
- ☐ use more pillows to
- ☐ swollen feet or ankles
- ☐ leg cramps
- ☐ heart murmur

Digestive
- ☐ heartburn
- ☐ bloating stomach
- ☐ belching
- ☐ stomach pain
- ☐ nausea
- ☐ vomiting blood
- ☐ difficulty swallowing
- ☐ constipation
- ☐ loose bowels
- ☐ black stools
- ☐ gray stools
- ☐ pain in rectum
- ☐ rectal bleeding

Urinary
- ☐ night frequency
- ☐ day frequency
- ☐ wetting pants or bed
- ☐ burning on urination
- ☐ brown, black, or bloody urine
- ☐ difficulty starting urine
- ☐ urgency

Male Genital
- ☐ weak urine stream
- ☐ prostate troubles
- ☐ burning or discharge
- ☐ lumps on testicles
- ☐ painful testicles

Female Genital

last menstrual period ___/___/___
- ☐ vaginal bleeding

Have you had a hysterectomy?

Are you post menopausal?
- ☐ abnormal IMP
- ☐ heavy bleeding during menses
- ☐ bleeding between periods
- ☐ vaginal itching or discharge

Do you do self breast exams?
- ☐ lump or pain in breast

Do you use birth control?

Method: _____

When was your last pap test?

____/____/____

Obstetric History

How many times have you been Pregnant? ____

of children ___

of premature births ___

Musculoskeletal
- ☐ aching muscles
- ☐ aching joints
- ☐ swollen joints
- ☐ shoulder pain
- ☐ back pain
- ☐ painful feet
- ☐ handicapped

Skin
- ☐ skin problems
- ☐ itching skin
- ☐ burning skin
- ☐ bleed easily
- ☐ bruise easily

Neurological
- ☐ faintness
- ☐ numbness
- ☐ convulsions
- ☐ change in handwriting
- ☐ trembles

Mood
- ☐ nervous with strangers
- ☐ difficulty making decisions
- ☐ lack of concentration
- ☐ poor memory
- ☐ lonely or depressed
- ☐ cries often
- ☐ hopeless outlook
- ☐ difficulty relaxing
- ☐ worrisome
- ☐ frightening dreams/thoughts
- ☐ dislike criticism
- ☐ loses temper easily
- ☐ annoyed easily
- ☐ work or family problems
- ☐ sexual difficulties
- ☐ considered suicide
- ☐ desired psychiatric help

General
- ☐ gained/lost more than 10 lbs
- ☐ tend to be too hot or cold
- ☐ loss of appetite
- ☐ always hungry
- ☐ more thirsty lately
- ☐ armpit or groin swelling
- ☐ exhausted or fatigued
- ☐ sleeping difficulties
- ☐ exercise less than 3x/week
- ☐ use sleeping pills or sedatives
- ☐ use hard drugs
- ☐ drive a vehicle over 25K/yr

PROBLEMS SUMMARY

Name: **Date of Birth:** **Allergies:**

Chronic/Recurring Problems: Date of onset/Recorded

CONTINUING MEDICATIONS AND SUPPLEMENTS

Medications:	**Date**	**Dosage**	**D/C**	**Medications:**	**Date**	**Dosage**	**D/C:**

Supplements:	**Date**	**Dosage**	**D/C**	**Supplements:**	**Date**	**Dosage**	**D/C:**

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Financial & Service Agreement

In order to familiarize you with the nature of services provided by Marcey Shapiro, MD and her staff the following information is provided:

Finances

It is the policy of our office to maintain your account on a current basis. Payment for services is due at the time of visit. We accept personal checks, cash, or credit cards (Mastercard/Visa/American Express only). If payment on the day of your visit is a concern, please speak with our office manager about setting up a payment plan *prior* to your appointment.

If you have health insurance coverage, we will provide you with a properly coded receipt to submit to your insurance company. *Our office does not provide insurance billing*. It is your responsibility to follow up with your carrier regarding reimbursement. *To reiterate: Payment for services is due at time of visit.*

Questions and Advice

We are happy to answer brief questions you may have in between appointments.
You can email us at office@marceyshapiromd.com. If there are multiple questions or the issue is too detailed we will suggest an office visit or phone consultation with Dr. Shapiro.
You are also welcome to fax us questions at 510-526-9648.

Supplements

You are welcome to order refills of supplements recommended to you by Dr. Shapiro. We ask that you phone or email your request in advance so that we can have it ready for you in a timely manner. If picking them up is inconvenient we can arrange to mail them to you for a small postage/handling fee.

Appointments

Appointments are usually available Monday, Wednesday, and Thursdays from 10 –5:30 p.m. We ask that you give us at least 48 hours notice when you wish to cancel or reschedule an appointment. *You will be charged the full office visit fee if you miss an appointment, or cancel with less than 24 hours notice.*

Please read and sign our service agreement below.

I am aware that as a consulting physician specializing in complementary medicine, Marcey Shapiro, MD is not available nights, weekends and/or specific holidays throughout the year and that she does not admit patients to hospitals. **In addition to being a patient of Dr. Shapiro's, I understand that it would be in my best interest to have a primary care physician with hospital 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 doctor.

_____ _____

Signature Date

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PRIVATE CONTRACT

I, _____ do hereby understand and acknowledge that as of April 1, 1999 Dr. Marcey Shapiro, MD has opted out of participation as a Medicare provider and that the following is true and correct:

1. I agree not to submit a claim to Medicare for services provided by Dr. Marcey Shapiro, MD or to ask Dr. Shapiro to do so on my behalf. In doing so, I acknowledge that I am giving up all Medicare coverage of and payment for items and services furnished by Marcey Shapiro, MD.
2. I acknowledge that, under this contract, Medigap plans do not make payment for items and services furnished by Dr. Marcey Shapiro and that other supplemental insurance carriers may not either.
3. I agree to be fully responsible for payments due Dr. Marcey Shapiro for items and services rendered, without such limits as would otherwise be imposed by Medicare.
4. I acknowledge that I have the right to receive items and services from another physician or practitioner who is a participating Medicare provider.
5. I understand that Dr. Marcey Shapiro is hereby excluded from participation in the Medicare program under Section 1128 of the Social Security Act.

My signature below indicates that I have read and understand all of the above and agree to abide by this contract.

Patient Signature _____ Date _____

Dr. Marcey Shapiro, MD _____ Date _____

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General Office Information

Office Hours:

Mon, Tuesday, Thurs: 10 am-5:30 pm; Wed 11 am-3 pm, Fri: 11 am-5 pm
We are closed for lunch every day from 1:00 pm – 2:00 pm

For our new patients, and for our continuing patients who are unaware, we would like you to know some of our general office policies. We ask for your understanding and assistance with upholding these policies so that we may better provide you with a calm and pleasant office atmosphere and experience.

It is our highest priority to take care of the patients who are being seen by Dr. Shapiro during each day. **It takes time to prepare the recommended supplements, lab requisitions, and necessary paperwork for patients who are exiting. Please be patient with us as we tend to these people in order that you may receive the same level of care at the end of your own appointment. That said, we will always do whatever we can to tend to the needs of incoming patients, it just may take a moment.**

Ways that you can help us create this environment:

- Schedule appointments in advance! Dr. Shapiro typically has a 2-4 week wait for new patient appointments and a 1-3 week wait for follow-ups, although patients who need an appointment sooner can often be accommodated on a cancellation wait list if they are flexible about scheduling. Please use common sense when referring people to our office, and consider whether it might be better to call an urgent care center or the emergency advice nurse at a hospital.

- Avoid calling multiple times in order to reach a live person unless absolutely necessary. We check our voicemails first thing in the morning, immediately after lunch, and usually a third time before the day is out. We will return your call as soon as possible!

- Avoid wearing fragrances or other scented products. ***This is a fragrance-free health care environment. Because we are concerned for the safety and well-being of our patients and staff, kindly avoid using fragrances and scented products. We have staff and a number of patients who suffer from ailments that cause them to be highly sensitive and/or allergic to fragrances of all types.***

- Call supplement orders in ahead of time! We love it when you call ahead, or better yet e-mail us, with your supplement requests a week or so in advance. This gives us plenty of lead-time to let you know if we are out of something and get as much as possible ready for you for when you arrive. If you call, please leave a detailed message with your request and speak your name and phone number clearly and slowly. If you have phoned or e-mailed an order in to us prior to your appointment, **please remind us when you arrive**.
If you cannot call or e-mail orders ahead of time, or you forget, please be mindful of the fact that we may not be able to assist you immediately when you come into the office. Please also keep in mind that we do not always have everything in stock, and you will only be able to pick up what we have available at the time you are here.

- Request prescription refills well before you will run out! We can usually call or fax refill requests in within a day, but if Dr. Shapiro is out of town, or if there is a problem with the prescription on the pharmacy end, it can delay the process considerably, potentially jeopardizing your well-being. We will do our best to accommodate you, but **it is your responsibility to make such requests well in advance** of when you need it.

- Avoid immediate-need paperwork requests. Please, plan ahead! Requests such as copies of receipts, lab reports, medical records, special forms, etc. will be fulfilled within a week or less, but usually cannot be done immediately. To reiterate the point above, it is our priority to take care of the patients who are being seen by Dr. Shapiro. We will tend to other requests as soon as possible.

It is our general policy to contact you after your lab reports have come in and Dr. Shapiro has reviewed them and made notes. **We will always call you after this happens, even if your lab reports are normal.**

- Maintain a strong relationship with your primary care physician. Every patient should have a primary care provider! Dr. Shapiro is a complementary care physician. She does not maintain hospital privileges, and sometimes she is out of town and not available for contact for a week or so at a time. In the unfortunate event that you need emergency care, we want you to be taken care of, and this is best achieved by establishing a relationship as a patient with a doctor who is your primary care physician.

Cancellation policy:

We ask that you give us at least 48 hours notice when you wish to cancel or reschedule an appointment. *You will be charged the full office visit fee if you miss an appointment, or cancel with less than 24 hours notice*.

For new patients we request a 72-hour cancellation notice. A cancellation fee of $100 will be charged for new patient appointments cancelled with less than 48 hours notice.

Insurance and Medicare:

Please note that Dr. Shapiro is not a member of any insurance group and the office does not bill insurance companies. We will provide you with an insurance-acceptable "super bill" showing the charges and what you paid, along with diagnostic codes, which you can submit to your insurance company for reimbursement. Dr. Shapiro has opted out of Medicare. Please see the enclosed financial agreement for more information.

We are grateful for your patronage of Dr. Shapiro's practice. We strive to provide a friendly environment where you feel taken care of. Thank you for helping us fulfill this goal!