

INTEGRATIVE MEDICINE OF NEVADA

Christi Bonds, M.D.

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PATIENT INFORMATION

Please complete all sections of this form.

PLEASE PRINT

Date _____

PERSONAL INFORMATION

LAST NAME _____

HOME TEL. # _____

FIRST NAME /S _____

BUSINESS TEL # _____

ADDRESS _____

REFERRED BY _____

CITY _____

SOCIAL SECURITY # _____

STATE _____ ZIP _____

RELIGIOUS PREFERENCE _____

BIRTHDATE _____

RESPONSIBLE PARTY _____

SEX Male Female

NAME OF SPOUSE _____

MARITAL STATUS Single Married Divorced
 Widowed Separated

NAME OF PARENTS _____
(if a minor)

MEDICAL DATA

Are you allergic to medications (Penicillin, Vit. B-12, etc.)? _____

Are you allergic to Procaine, Lidocaine, Xylocaine or Novocaine? _____

Do you have pets? _____ What kind? _____ Do they live in your home? _____

Habits

Do you drink coffee or regular tea? _____ How much? _____

Have you ever used alcohol? _____ How much and how often? _____

Do you smoke or did you ever use tobacco? _____ How much and for how long? _____

Have you ever used heroin, cocaine, LSD, PCP, marijuana, etc.? Which ones and how frequently? _____

Have you ever used sleeping pills and /or pain pills? _____ How often? _____

Do you handle chemicals? _____ Which ones and to what extent? _____

Do you exercise regularly? _____ What type and how often? _____

Patient Information and Informed Consent

1. Acknowledgement -- Notice to Medicare Subscribers

Please be advised that Christi Bonds, MD, does not accept assignment for Medicare. Therefore, please be advised that Medicare may not cover the expenses they feel are medically unnecessary. Medicare does not recognize medical acupuncture, electro-acupuncture, homeopathy, or nutritional counseling.

2. General Disclaimer regarding Non-toxic Therapy

Homeopathy, acupuncture, electro-acupuncture, Chinese herbal therapy, nutritional counseling, and bioenergetic medicine may not be recognized by some insurance companies, the FDA or mainstream medicine as reimbursable or acceptable. Nevertheless, in expressing my constitutional right of freedom of choice of medical care, I choose to be diagnosed and treated by Christi Bonds, MD.

RELEASE OF INFORMATION -- I hereby authorize release of my medical information to the physician(s) I have been referred to by Christi Bonds, MD, or any person designated by me, and to my insurance carriers.

I have read, understood and agree to the above statements.

Patient's signature: _____ Date: _____

Parent/Guardian, if Minor: _____

