RONALD D.ROSEN, MD, PC
OPEN PATHS
918 NE 5TH ST
BEND, OR 97701
541-388-3804

PATIENT REGISTRATION FORM TODAY'S DATE_____

Please complete this form in its entirety.

Patient's Name: _____ _____ ___
LAST FIRST MI

Date of Birth_____ SS#_____ Sex M F

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work:_____ Cell:_____

Email (optional if you want email correspondence)_____

Employer/School:_____ Occupation:_____

Are you: Single Partnered Married Divorced Widowed

Do you live: Alone Partner Parents Other

Spouse/Partner's Name: _____ _____ __
LAST FIRST MI
Phone number/Numbers:_____ _____ _____

Emergency Contact:_____ _____ _____
NAME RELATIONSHIP PHONE NUMBER

Can we call and leave a message in your phone number re: results, appointments? Y N
If not what phone may we use? _____

How did you find my practice?_____

Do you have medical insurance? If yes name and group/ID number:_____

Do you have Medicare as your primary insurance?__

INSURANCE ACKNOWLEDGEMENT; ALL PATIENTS SIGN (INCLUDING MEDICARE)

I_____ have been informed the Ronald D. Rosen, MD,PC and his office don't do any insurance billing and is has "opted out" of Medicare. I agree to pay in full all services provided by Dr. Rosen and understand that all payments for services and supplements are due at the time of service. I understand that I have a direct relationship as a client/customer with my insurance company and that Dr. Rosen will provide me with a receipt for each visit or supplement purchase. I understand that in some instances my insurance may not cover certain services provided by Dr. Rosen.
In most cases supplements are not covered by insurance. I also understand that Dr. Rosen has no direct relationship with any insurance company and is thus not an intermediary between my insurance company and myself.

Print Name:_____ Date:_____

Signature_____ Witness:_____
(IF a minor, parent's signature please)

MEDICARE PATIENTS ONLY
I_____ enter into a private medical contract with Dr. Ronald D. Rosen. I understand that Dr. Rosen has "opted out" of Medicare. I agree to pay in full for all services provided by Dr. Rosen or his staff. I understand that Dr. Rosen is excluded by his own volition from participating in the Medicare program under section 1128 of the Social Security Act. I agree not to submit any claims or request Dr. Rosen to submit any claim for payment under Medicare, even if Medicare would otherwise cover such services and items. I acknowledge that Medigap will not pay towards the services and that other supplemental insurers may not pay either.

Treatment options: (This section is to be signed after the procedures have been explained,)

Signature:_____ Witness:_____

Treatment options: (This section is to be signed with Dr. Rosen or staff after these options have been discussed.)
IV Myers, IV EDTA, IV DMPS, IV high dose Vitamin C, IV H_2O_2, Acupuncture, Manual Medicine treatment, Acupuncture. Dr. Rosen has explained the seceted procedure/procedures to me.

Print Name:_____ Date:_____

Signature(If minor parent's signature)_____ Witness_____

MEDICAL HISTORY

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING: (Please circle)

Allergy to foods Anemia Asthma Autoimmune disease Broken bones Bulimia Cancer Cardiac arrest Chronic Fatigue Diabetes Fainting Spells Heart arrhythmias Hypertension

Major depressive episodes Multiple antibiotic use Pacemaker Prolonged insomnia Recurrent infections Seasonal affective disorder

Please explain if you have or had any of the above_____

LIST ANY MAJOR MEDICAL ILLNESS YOU HAVE HAD AND DATES:

1_____ 2_____

3_____4 _____

5_____6_____

LIST ANY SURGERIES AND DATES:

1_____2_____

3_____ 4_____

5_____ 6_____

ANY TRAUMATIC EVENTS IN YOUR LIFE (both physical and emotional):

1_____ 2_____

3_____4_____

ALLERGIES TO FOODS, ENVIRONMENT OR MEDICATIONS:

1_____2_____3_____

4_____5_____6_____

HISTORY OF CHEMICAL EXPOSURE:_____

FEMALES ONLY:

Age of first menstrual period____ Date of last menstrual period_____
Days in cycle____ Days period last___ heavy or light?
Last PAP smear____ Last mammogram_____ Do you perform self breast exam__
Number of pregnancies__ Any complications during pregnancy_____ Number of live births___ Miscarriages__ Abortions__
Do you use or have used birth control pills__ How long__ Currently__

LIST MEDICATIONS YOU ARE PRESENTLY TAKING, DOSAGE AND FOR HOW LONG:
1_____ 2_____
3_____ 4_____
5_____ 6_____
7_____ 8_____

LIST OF SUPPLEMENTS, HERBS, VITAMINS, ETC, DOSAGE AND FOR HOW LONG:
1_____ 2_____3_____
4_____ 5_____6_____
7_____ 8_____9_____
_____

LIST ANY EXERCISE, YOGA, MEDITATION AND TIME SPENT A DAY:

USUAL DIET:
Breakfast_____
Lunch_____
Dinner_____
Snacks_____
Beverages_____

SUBSTANCE USE:

Cigarette smoking_____ Amount per day_____ For How long____ Quit ___ When____
Other Nicotine use_____Amount per day_____ For how long_____Quit____When____
Alcohol use_____ Amount per day_____For how long_____Quit___When____
Recreational drugs_____
OTHER:
Favorite book/books_____
Favorite movie_____
Are you happy?_____
What would you change in your life? _____

FAMILY MEDICAL HISTORY:

Father:_____

Mother:_____

Paternal grandfather:_____

Paternal grandmother:_____

Maternal grandfather:_____

Maternal grandmother:_____

Uncles/Aunts/Cousins with cancer history:_____

Siblings:_____

SELF-ASSESSMENT HEALTH PROFILE

Name_____ Date_____

Check the symptoms you have experienced during the last 3 months. CIRCLE the ones that have been most troublesome.

DEFICIENT QI
__weak, lethargic, fatigued
__dull feeling
__excessive need for sleep
__susceptible to colds, flu
__long recovery after illness
__short of breath
__perspires easily
__feels cold
__frequent large urination
__dizzy or weak after a meal or bowel movement

DISTURBED SHEN
__restlessness and agitation
__emotionally unstable
__sudden rage, panic
__constant anxiety, worry
__easily startled
__erratic sleep, disturbing dreams
__delirium

DEFICIENT MOISTURE
__perspires easily at rest
__very thirsty
__extreme dryness to skin or mouth
__constipation
__uncomfortably hot or warm
__afternoon fever or heat
__night sweats

STAGNANT QI
__nausea or acid stomach
__distention or fullness to belly
__vague intermittent pains
__pressure to head, chest limbs
__intermittent pain to ribs, flanks
__difficulty swallowing
__stuck feeling to throat

__emotional lability
__persistent dry cough
__persistent dry sore throat
__flushed face
__persistent stabbing pains

DEFICIENT BLOOD
__restless fatigue
__difficulty in falling asleep and anxious
__itching scalp or skin
__dry and no thirst
__blurred vision
__restless and excitable
__mood swings (laughs easily cries easily)
__thick sticky phlegm or secretions

SPLEEN NETWORK
__bruise easily
__tender muscles
__difficult bowel movements
__self absorbed
__feel unstable or ungrounded
__diarrhea
__indigestion
__frequent abdominal bloating
__frequent loose stools
__difficulty digesting raw foods
__hunger after meals
__hard to gain or loose weight
__variable appetite
__difficulty focusing
__overwhelmed by details
__easily worries
__lethargy
__prolapsed uterus, vagina, hemorrhoids
__excessive bleeding from cuts or menses
__lack of muscle tone
__water retention
__heavy prolonged menses

STAGNANT BLOOD
__angina
__constant all day headaches
__easy bruising
__cold hand -feet
__irregular, painful menses
__sever menstrual cramps
__hard lumps or masses
__numbing arms, legs

DAMP
__edema of face, ankle, feet
__mucus or phlegm in chest
__mucus in nose or throat
__generalized heavy sensation to body
__greasy stools
__heavy sensation to head
__loose stools
__sore, heavy muscles or joints
__mobile lump

LUNG NETWORK
__weakness
__ dry mucous membranes or skin
__environmental allergies
__skin rashes, eczema, hives
__runny nose, stuffed sinuses
__sensitive to wind, dry cold weather
__frequent lingering coughs, colds
__easily offended
__life has no meaning
__disconnected from others
__constant phlegm in chest
__shortness of breath, wheezing

HEART NETWORK

__insomnia when worried, nervous
__craving for cool drinks, or hot spicy food
__sores of mouth or tongue
__burning to mouth or tongue
__palpitations when nervous, upset or fatigued
__lack of excitement
__easily overheats
__palpitations when nervous, upset or fatigued
__anxiety
__insomnia, waking up middle of night
__mood swings
__cravings for cool food or spicy
__sore or burning to tongue, mouth
__vivid dreams, nightmares
__easy blushing

LIVER NETWORK

__lack clarity or purpose
__tight tendons or muscles
__frequent headaches from tension
__migraine headaches
__tension to shoulders, upper back, hips
__dry eyes
__blurred vision
__dizziness,
__numbness, tingling to arms or legs
__dry hard stools
__pain to flank, ribs
__bitter taste with acid reflux
__dizzy, queasy, headache from tension, anger or frustration
__high pitched ringing in the ears

KIDNEY NETWORK

__puffy eyes
__decreased libido
__impotence
__loss or thinning of hair, pubic hair
__early cessation of menses
__infertility
__profuse or scanty urination
__frequent or difficult urination
__decrease range of motion or flexibility of spine
__weak bones, joints
__sore back, hips, knees or feet
__easily fatigued
__forgetful
__mental dullness