Natural Healing Center of Myrtle Beach

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4810 N. Kings Highway
Myrtle Beach, SC 29577

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill *is* considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our Information Form before seeing the Doctor.

• FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
• WE ACCEPT CASH, CHECKS, VISA /MASTERCARD, MONEY ORDER, AMERICAN EXPRESS.
• WE DO NOT ACCEPT ANY INSURANCE PLANS

Adult Patients: Adult patients are responsible for full payment at the time of service.

Minor Patients: The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a Visa/MasterCard, or payment by cash or check at the time of service has been verified.

Missed Appointments: Unless cancelled, please allow at least 24-hours in advance.

If you (the patient) miss office visits with Dr. Dong or to the prescribed appointments or therapy, this office is not liable for any adverse physical, mental or emotional complications resulting thereof.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

FINANCIAL POLICY
"SUMMARIZED"

• Full Payment Is Due at Time of Service
• No Post-dated Checks Accepted
• No Payment Plans Available
• Please Consult With Our Staff before Your Appointment, If You Need to Discuss Finances
• Checks Written For Insufficient Funds, Will Require Cash or Money Order Immediately For Original Amount, Plus a $50 Service Fee
• We Do Accept Cash, Local Checks, Visa/MC/American Express or Money Order

I understand and agree to this Financial Policy

X____
Patient Name (PRINTED)

X____X___________________________
Signature of Patient or of Responsible Party Date

X____X___________________________
Signature of Co-Responsible Party Date

Patient Name (Printed) ______________________________________

PATIENT INFORMATION

Name: ____M{ } F{ }

D.O.B_____/_____/_____ SS#_______-______-_______

Address:____

City:____

Home Phone #:____

Cell Phone #________________________________

Email address:____

Employer____

Address____

State: ____________Zip code:__________________

Phone Ext____

Marital Status (Circle One) S M D W Sep

Spouse's Name____

Employer:____

EMERGENCY INFORMATION:

Nearest relative (not living with you)

Name____

Next nearest relative:______________________________________

Name____

*Person for Emergency Contact:*___________________________________

Name____

LIFESTYLE HISTORY

Do You Frequently Skip Meals? Yes / No

If Yes, Which Meal Do You Most Often Skip?___________________

Why?____

Do You Feel Better After Eating or Worse?

____

Do Certain Foods Irritate You In Some Way?

____

Describe Symptoms For Foods That Irritate:

____

Do You Crave Certain Foods/Spices? Yes / No

Which Ones?____

What Foods Do You Especially Like/Dislike/Avoid?

Like:____

Dislike:____

Avoid:____

Do You Feel Your Diet Is (Excessive / lacking / deficient) in Some Respect?

Describe:____

Do You Gain/Lose Weight Easily? Gain / Lose

Have You Ever Smoked Cigarettes? Yes / No

If Yes, How Many Packs Per Day?_________________ How Many Years?_________________

Do You Smoke Now? Yes / No If No, How Many Years Ago Did You Quit?___________

How Many Bowel Movements Do You Have Per Week?____________________

Circle One: Light Moderate or Heavy___________________________________

How Many Times Do You Exercise Every Week? Type of Exercise:

Aerobic: Yes / No Stretching: Yes / No Muscle Toning: Yes / No

How many hours a night do you sleep a night? __________________

How many hours a day do you work? __________________________

Patient Name (Printed) __________________________________

Please List Any Nutritional Supplements, Vitamins That You Are Taking:
____
____
____
Have you taken Repeated Rounds of:
Antibiotics ____
When? ____
How often? ____
Steroids: ____
When? ____
How often? ____
Birth control pills:
When? ____
How often? ____
How many times per week do you shower?____________________________
Are you now or have you been subjected to any Environmental Pollution? YES / NO
Chemicals at work:____
Chemicals at home:____
Mold:____
Mildew:____
Dust:____
Automobile exhaust:____
Second hand cigarette smoke:____

OTHER LIFESTYLE/NUTRITIONAL/ENVIRONMENTAL QUESTIONS
On a scale of 1 to 10 (1 being very little/none, 10 being very much/a lot), please answer the following questions by circling your selection (number).
1. How much do you have difficulty sleeping soundly or going to sleep?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
2. How much do you wake up feeling exhausted?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
3. How much and often do you feel tired and fatigued during waking hours?
Circle one: 1 2 3 4 5 6 7 8 9 10
4. How much do you feel your Health Challenges are related to Emotional/Mental Imbalances?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
5. How much do you have people in your life who will listen to you talk about your problems?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
6. How much are you supported/believed in by other people in your life?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
7. How much do you feel isolated or lonely?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
8. How much do you believe you can overcome your Health Challenges?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
9. How much do you desire (want to) and are willing to work at overcoming your Health Challenges?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
10. What seeming circumstances in your life (right now) might hinder you from making necessary changes to Regain and maintain your Health?
Family Challenges
Circle one: 1 2 3 4 5 6 7 8 9 1 0

Patient Name (Printed) **___________________________________**

Financial Limitations
Circle one: 1 2 3 4 5 6 7 8 9 1 0
Emotional Problems
Circle one: 1 2 3 4 5 6 7 8 9 1 0
Support System Lacking
Circle one: 1 2 3 4 5 6 7 8 9 1 0
11. How much do you eat Fast Food?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
12. How much do you eat Junk Food?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
13.If taking medication, how much do you desire to eliminate or reduce you need for medication?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
14. How much do you know about Preventative Medicine Principles, Alternative Holistic Approaches to healing. Diet, Nutrition, Lifestyle, Environment, etc.?
Circle one: 1 2 3 4 5 6 7 8 9 1 0
Your Country Of Origin:________________________________
Parent's Country Of Origin: Mother__________________ Father__________________
List All Areas Where You Lived Or Traveled To:_______________________________
____
Do You Travel Frequently? ________________________________
Do Yon Currently Live In: City / Suburbs / Country
Current Occupation: ____
Previous Occupations (If different From Current): _______________________________________
____
____
Please List Your Four Major Health Complaints In Order Of Importance And Indicate How Long You Have Had The Problem:
1.___________________________________ 3.______________________________________
2.___________________________________ 4.___________________________________
What Are Your Goals In Terms of Health?____
____
Are You Willing To Make Changes/Adjustments In Your Life-Style To Reach Your Desired Health Goals?____
FAMILY HISTORY: (Who and What Disease):
____
____
____
____
____

PERSONAL HEALTH HISTORY:
Childhood Illnesses: Measles Mumps Chicken Pox Whooping Cough, Other(explain)
____
____
Were You Vaccinated As A Child? NO / YES
Which vaccines?____
____
____
Were You Prone to Infection As a Child? Yes ____No____ Type:____________________
____

Patient Name (Printed) ______________________________________

DENTAL HEALTH: Do You Have or Have You Had Any Of The Following?

Gum Disease/Bleeding Periodontal Disease (Pyorrhea) Yes / NO

Tooth Extraction: NO / YES

Dental Amalgams (Fillings) : NO / YES

Crowns: NO / YES

Bridges : NO / YES

Dentures: NO / YES

Implants: NO / YES

Root Canal: NO / YES

Mouth Ulcers: NO / YES

TMJ Syndrome/Pain: NO / YES

Increased Salivation: NO / YES

Metallic Taste NO / YES

Excessive Cavities/Decay: NO / YES

Sensitive Teeth: NO / YES

Bad Breath NO / YES

Braces/Appliances: NO / YES

Burning Sensation In Mouth Or Tongue: NO / YES

Dental Surgery NO / YES

Do You See A Dentist Regularly? Yes / No

Do You Have Mercury Amalgam ("Silver") fillings in your mouth? NO / YES

Do You Have or Have You Ever Had An Eating Disorder? NO / YES

If Yes, What Type____

Are You Allergic To Any Pharmaceuticals **Or** Natural Remedies? Please List:_______________

____

____

What Other Permanent Disease Conditions Have You Been Diagnosed With?________________

____

____

____

Types of Treatments You Have Had in the past and for What Conditions:___________________

____

____

____

Do You Believe That These Diagnoses Are Accurate? NO / YES

If Not, Why Not?____

What Do You "Peer or "Think" Is Wrong with You?_____________________________________

____

Do You Get Regular Check-ups? Yes / No

Major Illnesses and Approximate Age/Dates:_______________________________________

____

____

Surgery and Approximate Dates (Including Dental Surgery):________________________________

____

____

Current/recent Medications:

1.____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

9. ____

10. ____

Pregnancies:

How many children born alive:____

How many still births:____

Patient Name (Printed) ________________________________

How many premature births:____
How many Cesarean Sections:____
How many miscarriages:____
Any complications with pregnancy explain:
____
____

Neurological System
Frequent or severe headaches.____
Epileptic seizures/convulsions____
Tingling or weakness of hands/feet: No / Yes
Loss or change in sensation of hands/feet: No / Yes
Fainting spells: No / Yes
Weakness: No / Yes
Stroke: No / Yes
Testicular mass/pain: No / Yes
Prostate trouble____

Psychological System: (Circle all that apply)
Exhausted, tired, drained, overwhelmed
Pressured, tense or stressed
Nervous, panicky, worried, anxious, fearful
Annoyed, irritable, resentful, angry
Frustrated, Bored, unmotivated, Uninterested
Inadequate, inferior, Guilty, ashamed
Lonely, unloved, alone
Sad, depressed
Hopeless, discouraged
Alcohol, drug abuse

What Types of Diagnostic Tests You Have Had In The Past?
Please list any tests that were Positive and the findings:
____
____
____
____
____
____
____
____
____
____
____

Patient Name (Printed) ___________________________________