

**REGISTRATION FORM**

***ABOUT YOU:***

**Patient Name** \_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**City, State, Zip** \_\_\_\_\_  
**Home Phone** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_  
**Birth Date** \_\_\_/\_\_\_/\_\_\_ **Sex:** M / F **Patient Status:** S / M / D / Other  
**S.S.#** \_\_\_/\_\_\_/\_\_\_  
If applicable Spouse or Significant Other' Name \_\_\_\_\_  
**Referred** by name/phone \_\_\_\_\_  
**Primary Care Physician:** Name/Address \_\_\_\_\_  
**Student Type:** Student, Full Time / Student, Part Time / Non-Student  
**Employee Type:** Retired / Employed Full Time / Employed Part Time / Not Employed  
**Employer** \_\_\_\_\_  
Occupation \_\_\_\_\_

***BILLING INFORMATION:***

Person Responsible for Payment \_\_\_\_\_  
Relationship to you \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work \_\_\_\_\_

***EMERGENCY CONTACT INFORMATION:***

Name \_\_\_\_\_  
Relationship to You \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

***INSURANCE INFORMATION:***

**Primary Insurance Company** \_\_\_\_\_ Phone \_\_\_\_\_  
Claim mailing address \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Policy Holder Employer \_\_\_\_\_ DOB \_\_\_\_\_ Sex: M / F  
Insurance ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Phone \_\_\_\_\_  
Claim mailing address \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Policy Holder Employer \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Sex: M / F  
Insurance ID# \_\_\_\_\_ Group# \_\_\_\_\_

*ADVANCED DIRECTIVE:*

Do you have advanced directives such as a medical power of attorney or instructions that describes your wishes if you become critically ill? \_\_\_Yes \_\_\_No

If so please bring in a copy so we can put it in your record.

If not, we recommend you think about making such plans.

*AGREEMENT:*

By signing below, I consent to medical treatment rendered by Mark L. Hoch, MD. I understand that I will receive a full explanation prior to any testing, procedure or referral and that I will be given the opportunity to seek further information or decline services.

By signing below, I agree to assume and to pay the fees for services rendered to me. I understand that payment for services received is my responsibility unless other arrangements are made beforehand. **Payment is due at the end of each visit.**

I may receive an itemized bill with nationally recognized codes for services rendered. If applicable the office will submit a claim to your insurance company to help you get reimbursed directly. **It is always best to check with your insurance company prior to your visit to verify what services you have coverage for.** Most plans have out of network benefits for medical care.

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Client Signature

Date

## **RIGHTS AND RESPONSIBILITIES**

*For our part of the healthy relationship we strive to have with you, we commit to your enjoying the following rights:*

To respect and dignity. This includes considerate, respectful care at all times.

To privacy and confidentiality.

To be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.

To expect all communication or consultation involving your care to be conducted discretely and to only include individuals directly involved in your care.

To expect all communication and records pertaining to your care to be kept confidential (at least as strictly as required by law).

To refuse to talk with or see anyone not officially connected with the center, including visitors or persons officially connected with the center but not directly involved with your care.

To consent to or refuse the taking of pictures for the center's use.

To personal safety.

To know the identity and professional status of individuals providing services to you.

To current information (to the degree known) concerning diagnoses and treatments.

To consent to or to refuse treatment.

To be provided as much information about proposed treatments or procedures as needed to make an informed decision. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternative treatments including no treatment, the risks involved in each, and the name of the person who will carry out the treatment.

To be informed if the center proposes to engage in or perform research or educational projects affecting your care or treatment. You have the right to refuse to participate in any such activity.

To consultation, at your request and expense, with another healthcare professional.

To change physicians if the relationship is not conducive to a good therapeutic relationship.

OVER PLEASE

To request and receive an itemized explanation of your bill for services provided at the center.

To be informed of the centers rules and regulations applicable to your conduct as a client. (See policies and procedures form).

To expect concerns regarding care to be handled in a timely and efficient manner.

***In turn we expect the following from you:***

To provide complete and accurate information to the best of your knowledge and ability about present health concerns, past illnesses, hospitalizations, medication, and other important matters relating to your health.

To inform us about any unexpected changes in your condition.

To inform us if you do not understand or are not comfortable with a planned course of treatment and what is expected from you in that plan.

To follow through on the instructions and treatment plan we develop together, to the best of your ability.

To read and keep as a reference the centers policies and procedures.

***We are committed to assisting each person to restore and maintain their health. However, healing starts from within, and your active commitment to your healing process is a key determinant to your success. Please express your preferences, doubts and concerns so that we can work with them to assist you to your best health.***

## OFFICE POLICIES AND PROCEDURES

**An effective and healthy relationship requires conscious participation from each person involved.**

**We will do our best to provide excellent care and service to you. Please see rights and responsibilities page above.**

**We also ask you to be responsible for your part of the relationship.**

This includes:

Reading and filling out all appropriate forms given to you in the information packet before your first visit.

Arriving on time for appointments and calling ahead if an unexpected delay arises.

Making payment for services at the end of each visit.

### **Phone access:**

To make appointments please call 763-546-5797.

Dr. Hoch will be available to return calls or to get answers to simple questions to you if this is appropriate. For complicated questions or in depth discussions it is best to schedule an office visit. At times, especially if one lives far away, it may be appropriate to have a telephone appointment. There will be a fee for phone appointments. The fee depends on the length of the appointment.

### **Emergencies:**

After hours, if you have an emergency or very urgent medical situation you can reach Dr. Hoch on his pager at 612-703-1333. All non emergency calls during regular hours should go to 763-546-5797 EXT 103.

### **Test Results:**

Results will be communicated to you in person or by phone depending on the situation. For simple results, when arranged at the time the test is ordered, Dr. Hoch will call you by phone or send you a confidential note. Often times a follow up visit will be necessary to review results and develop plans based on those results.

### **Cancellation Policy:**

If you know you will not be able to make a scheduled appointment please call us as soon as you know. This will allow another person who needs an appointment to get into the office for needed care.

\*\*\*If you do not cancel or reschedule the appointment at least 24 hours ahead of time, there will be a fee charged. The fee depends on the length of the visit and will be approximately \$50-\$75. Cancellation fee for missing the initial appointment is \$125.

OVER PLEASE

**Fees and Payments:**

Payment is required at the end of the visit unless otherwise arranged prior to the visit.

At the end of each visit you are entitled to an itemized bill for services and treatments performed during the visit. The bill will have the nationally recognized medical codes for diagnosis and treatment that should be readily understood by any U.S. insurance company.

In most cases we can submit the bill directly to your insurance company to assist with in getting reimbursed. Have the insurance company send all reimbursements directly to you unless other arrangements have been made.

**Insurance:**

Dr. Hoch is currently not on any insurance plans. Depending on your insurance plan services will likely be covered completely or in part.

Please check with the benefits department of your plan prior to your visit to see what will be covered.

This is particularly important if you have an HMO or other plan which restricts your access to health care providers. Many plans with restricted access do have an out of network benefit which usually pays for the majority (70-80%) of out of network services.

**Laboratory and Radiology (X-ray) fees:**

Charges for all tests are payable directly to the laboratory or radiology facility. Most tests can be done at local laboratories and are usually covered by your medical insurance. You need to check with your plan to find out if they only cover tests and X-rays done at certain facilities or through certain companies. If this is the case it is your responsibility to go to one of these facilities if you want maximum reimbursement from your medical plan.

There may be times when we recommend using special laboratories. This may be done because the test is not available locally or because the quality of testing done at these laboratories makes the results significantly more accurate. For such tests we strongly recommend you pay the lab directly when you send in the specimen to avoid processing fees. These tests may be covered by your insurance plan. It is your responsibility to check with your health plan prior to the testing to see if such testing is covered by them.

**Records:**

A record of your visits is kept as required by good standard medical practice and by law. You are entitled to a copy of your records especially if needed by other healthcare professionals to provide you with the care you need. There is a small fee for copies of your records to cover the cost of copying and staff time.

**AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone# \_\_\_\_\_

I authorize \_\_\_\_\_

To disclose the following healthcare information:

\_\_\_ All my healthcare information maintained by \_\_\_\_\_

\_\_\_ My healthcare information relating to the following treatments or conditions:

\_\_\_\_\_

\_\_\_ My healthcare information for the following dates: \_\_\_\_\_

This healthcare information may be disclosed to:

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Mark L. Hoch, MD  
10201 Wayzata Blvd., #350  
Minnetonka, MN 55305  
763-546-5797 phone  
763-546-5754 fax

The purpose of this disclosure is at my request for ongoing medical care.

Please include the following;

- Office notes
- Consultations
- Hospitalization summaries
- Surgical procedure/operative notes
- Lab results including blood, urine, culture and biopsy reports
- Radiology reports

I understand that I do not have to sign this authorization. My refusal to sign will not affect my ability to receive treatment.

I understand that I may revoke this authorization in writing. If I do it will not affect any actions already taken by anyone based on this authorization.

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date

Printed name

Relationship to patient

**INTAKE QUESTIONNAIRE**  
**Mark L. Hoch, MD**

Please fill out this form as completely as you are able to **before** your appointment. The better prepared and organized you are the more time we can spend on developing an effective therapeutic plan or treatment.

Please keep answers simple. We will have time to discuss things in more detail during the visit.

***CURRENT CONCERNS:***

Name \_\_\_\_\_  
Today's Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Referred by \_\_\_\_\_

What is the main reason for your visit today?

Please list other health concerns about your health that are also important to you.

When did you first become aware of the main problem?

What else was happening in your life in the year before the main problem became an issue?

To what extent does this problem interfere with daily activities (home and family activities, work, sleep, etc.)?

What if anything seems to bring on or aggravate the problem (certain activities, positions, weather, time of day, heat or ice, certain situations, etc.)?

What if anything seems to relieve or improve the problem?

Please list any health care practitioners and there specialty or field of practice you have seen about this?

What tests and X-rays were done (if any)?

What did they think the problem was?

What treatments were prescribed or have you tried on your own, and have they helped?

***PAST MEDICAL HISTORY and SYSTEMS REVIEW***

Please check the appropriate column of any **significant** problems you have had with the following conditions.

PROBLEM NOW	PAST PROBLEMS
<input type="checkbox"/> Fatigue/low energy	<input type="checkbox"/>
<input type="checkbox"/> Weight loss	<input type="checkbox"/>
<input type="checkbox"/> Weight gain	<input type="checkbox"/>
<input type="checkbox"/> Food cravings, for what? _____	
<input type="checkbox"/> Fevers	<input type="checkbox"/>
<input type="checkbox"/> Rashes	<input type="checkbox"/>
<input type="checkbox"/> Eczema, Psoriasis	<input type="checkbox"/>
<input type="checkbox"/> Skin cancer	<input type="checkbox"/>
<input type="checkbox"/> Change in moles	<input type="checkbox"/>
<input type="checkbox"/> Headaches	<input type="checkbox"/>
<input type="checkbox"/> Seizures	<input type="checkbox"/>
<input type="checkbox"/> Dizziness	<input type="checkbox"/>
<input type="checkbox"/> Memory problems	<input type="checkbox"/>
<input type="checkbox"/> Concentration problems	<input type="checkbox"/>
<input type="checkbox"/> Concussion/Head injury	<input type="checkbox"/>
<input type="checkbox"/> Tremor	<input type="checkbox"/>
<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/>
<input type="checkbox"/> Tingling or loss of feeling	<input type="checkbox"/>
<input type="checkbox"/> Vision loss/macular degeneration	<input type="checkbox"/>
<input type="checkbox"/> Glaucoma	<input type="checkbox"/>
<input type="checkbox"/> Cataracts	<input type="checkbox"/>
<input type="checkbox"/> Hearing loss	<input type="checkbox"/>
<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/>

**PROBLEM NOW****PAST PROBLEMS**

- |                          |                                      |                          |
|--------------------------|--------------------------------------|--------------------------|
| <input type="checkbox"/> | Ear infections                       | <input type="checkbox"/> |
| <input type="checkbox"/> | Loss of smell or taste               | <input type="checkbox"/> |
| <input type="checkbox"/> | TMJ or grinding teeth                | <input type="checkbox"/> |
| <input type="checkbox"/> | Sore throats                         | <input type="checkbox"/> |
| <input type="checkbox"/> | Root canals                          | <input type="checkbox"/> |
| <input type="checkbox"/> | Tooth infections or extractions      | <input type="checkbox"/> |
| <input type="checkbox"/> | Silver/Mercury fillings in teeth     | <input type="checkbox"/> |
| <input type="checkbox"/> | Gum disease                          | <input type="checkbox"/> |
| <input type="checkbox"/> | Sinus problems                       | <input type="checkbox"/> |
| <input type="checkbox"/> | Seasonal allergies/congestion        | <input type="checkbox"/> |
| <input type="checkbox"/> | Asthma                               | <input type="checkbox"/> |
| <input type="checkbox"/> | Bronchitis                           | <input type="checkbox"/> |
| <input type="checkbox"/> | Pneumonia                            | <input type="checkbox"/> |
| <input type="checkbox"/> | Emphysema                            | <input type="checkbox"/> |
| <input type="checkbox"/> | Shortness of breath                  | <input type="checkbox"/> |
| <input type="checkbox"/> | Swallowing problems                  | <input type="checkbox"/> |
| <input type="checkbox"/> | Food allergies, to what? _____       |                          |
| <input type="checkbox"/> | Nausea                               | <input type="checkbox"/> |
| <input type="checkbox"/> | Vomiting                             | <input type="checkbox"/> |
| <input type="checkbox"/> | Heartburn or Ulcers                  | <input type="checkbox"/> |
| <input type="checkbox"/> | Abdominal pain                       | <input type="checkbox"/> |
| <input type="checkbox"/> | Indigestion/gas/bloating             | <input type="checkbox"/> |
| <input type="checkbox"/> | Diarrhea                             | <input type="checkbox"/> |
| <input type="checkbox"/> | Constipation                         | <input type="checkbox"/> |
| <input type="checkbox"/> | Gall stones                          | <input type="checkbox"/> |
| <input type="checkbox"/> | Blood in stool                       | <input type="checkbox"/> |
| <input type="checkbox"/> | High blood pressure                  | <input type="checkbox"/> |
| <input type="checkbox"/> | Chest pain or pressure/ Angina       | <input type="checkbox"/> |
| <input type="checkbox"/> | Heart attack                         | <input type="checkbox"/> |
| <input type="checkbox"/> | Congestive heart failure             | <input type="checkbox"/> |
| <input type="checkbox"/> | Heart valve problems/rheumatic fever | <input type="checkbox"/> |
| <input type="checkbox"/> | Irregular heartbeat or fibrillation  | <input type="checkbox"/> |
| <input type="checkbox"/> | Leg pain with exercise               | <input type="checkbox"/> |
| <input type="checkbox"/> | Swelling in ankles                   | <input type="checkbox"/> |
| <input type="checkbox"/> | Pain or burning with urination       | <input type="checkbox"/> |
| <input type="checkbox"/> | Frequent urination                   | <input type="checkbox"/> |
| <input type="checkbox"/> | Unable to hold urine                 | <input type="checkbox"/> |
| <input type="checkbox"/> | Kidney stones                        | <input type="checkbox"/> |
| <input type="checkbox"/> | Problems with sexual function        | <input type="checkbox"/> |
| <input type="checkbox"/> | Prostate problems                    | <input type="checkbox"/> |
| <input type="checkbox"/> |                                      |                          |

**PROBLEM NOW**

**PAST PROBLEMS**

- |                          |                                       |                          |
|--------------------------|---------------------------------------|--------------------------|
| <input type="checkbox"/> | Breast pain or lumps                  | <input type="checkbox"/> |
| <input type="checkbox"/> | First day of last menses _____        |                          |
| <input type="checkbox"/> | Irregular menstrual periods           | <input type="checkbox"/> |
| <input type="checkbox"/> | Painful periods or PMS                | <input type="checkbox"/> |
| <input type="checkbox"/> | Abnormal PAP test                     | <input type="checkbox"/> |
| <input type="checkbox"/> | Vaginal discharge                     | <input type="checkbox"/> |
| <input type="checkbox"/> | Hot flashes                           | <input type="checkbox"/> |
|                          | Number of pregnancies _____           |                          |
| <br>                     |                                       |                          |
| <input type="checkbox"/> | Broken bones, which ones? _____       |                          |
| <input type="checkbox"/> | Osteoporosis                          | <input type="checkbox"/> |
| <input type="checkbox"/> | Arthritis or joint pain               | <input type="checkbox"/> |
| <input type="checkbox"/> | Fibromyalgia                          | <input type="checkbox"/> |
| <input type="checkbox"/> | Neck pain                             | <input type="checkbox"/> |
| <input type="checkbox"/> | Back pain or sciatica                 | <input type="checkbox"/> |
| <input type="checkbox"/> | Scoliosis                             | <input type="checkbox"/> |
| <input type="checkbox"/> | Muscle pain or cramps                 | <input type="checkbox"/> |
| <br>                     |                                       |                          |
| <input type="checkbox"/> | Frequent infections, what kind? _____ |                          |
| <input type="checkbox"/> | Swollen glands                        | <input type="checkbox"/> |
| <input type="checkbox"/> | Hepatitis                             | <input type="checkbox"/> |
| <input type="checkbox"/> | Sexually transmitted diseases         | <input type="checkbox"/> |
| <input type="checkbox"/> | Yeast infections                      | <input type="checkbox"/> |
| <input type="checkbox"/> | Parasites                             | <input type="checkbox"/> |
| <input type="checkbox"/> | Lyme disease                          | <input type="checkbox"/> |
| <input type="checkbox"/> | Polio                                 | <input type="checkbox"/> |
| <br>                     |                                       |                          |
| <input type="checkbox"/> | Cancer, what kind? _____              |                          |
| <br>                     |                                       |                          |
| <input type="checkbox"/> | Thyroid problems                      | <input type="checkbox"/> |
| <input type="checkbox"/> | Hormone problems                      | <input type="checkbox"/> |
| <br>                     |                                       |                          |
| <input type="checkbox"/> | Occupational exposures                | <input type="checkbox"/> |
| <input type="checkbox"/> | Chemical, radiation, body fluids      | <input type="checkbox"/> |
| <input type="checkbox"/> | Fumes, noise                          | <input type="checkbox"/> |
| <br>                     |                                       |                          |
| <input type="checkbox"/> | Easily susceptible to stress          | <input type="checkbox"/> |
| <input type="checkbox"/> | Anxiety                               | <input type="checkbox"/> |
| <input type="checkbox"/> | Low mood/depression                   | <input type="checkbox"/> |
| <input type="checkbox"/> | Bad temper                            | <input type="checkbox"/> |

On a scale of 1 to 10 (10 being optimal health), please rate the following;

Your physical health \_\_\_\_\_

Your emotional health \_\_\_\_\_

Your mental health \_\_\_\_\_

Your social health \_\_\_\_\_

***MEDICATIONS, HERBS, and SUPPLEMENTS:***

Please list all of medications, herbs, and supplements you are taking now or in the past 3 months. Please include prescriptions and what you are taking on your own.

Please list the **dose** (how many milligrams), **how many** you take and **how many times per day** you take them.

Please list any **allergies** you have to medications, herbs, or supplements.

***HOSPITALIZATIONS and SURGERIES:***

Please list all hospitalizations and operations, the reason for each and the date.

***INJURIES and ACCIDENTS:***

Please list all injuries you have had since birth including falls, broken bones, car and bicycle accidents, sports injuries, concussions, bad sprains, severe wounds, etc.

***FAMILY MEDICAL HISTORY:***

Has anyone in your family had any of the following conditions?  
Please check the appropriate space.

	Father	Mother	Father's parents	Mother's parents	Siblings	Children
Heart disease	—	—	—	—	—	—
High blood pressure	—	—	—	—	—	—
Stroke	—	—	—	—	—	—
Cancer	—	—	—	—	—	—
Diabetes	—	—	—	—	—	—
Asthma / allergies	—	—	—	—	—	—
Kidney disease	—	—	—	—	—	—
Thyroid disease	—	—	—	—	—	—
Osteoporosis	—	—	—	—	—	—
Depression	—	—	—	—	—	—
Alcohol or drug problem	—	—	—	—	—	—

Is your mother living?

What age is she now or at time she passed on?

Is your father living?

What age is he now or at time he passed on?

***HEALTH MAINTENANCE and PERIODIC CHECK UPS:***

Very briefly please describe your diet including snacks and drinks.

How many glasses of water do you drink per day?

What is your weight now?

Highest weight?

Lowest adult weight?

Very briefly please describe your regular physical activity and exercise routine.

Very briefly please describe your hobbies and community activities.

Very briefly please describe your meditation and spiritual practice.

What time do you go to sleep each night?  
What time do you typically wake up in the morning?  
Do you feel rested after sleep?  
Any trouble falling asleep \_\_\_\_or staying asleep\_\_\_\_\_?

Did you ever smoke?  
If so, how many packs of cigarettes per day?                      How many years?  
Date of last smoke?

Do you drink alcohol?  
What type?    How many drinks per day or week?  
Have you ever had a problem with alcohol?

Do you drink any beverages with caffeine?                      How many per day?

Please circle any of the following you consider a significant source of stress in your life now.

Family relationships    Personal or family health    Work    School  
Finances    Housing    Legal    Time    Other stresses

Please list the dates of your last visit for the following.

Complete exam by a medical doctor  
Electrocardiogram  
Mammogram  
Pap Test  
Colonoscopy

Please circle the following therapies you have used.

Acupuncture	Traditional Chinese Medicine	Ayurvedic Medicine
Chiropractic	Healing Touch / Energy Medicine	Herbs
Homeopathy	Hypnosis	Guided Imagary
Massage	Other Body Work	Osteopathy
Spiritual Healing	Aromatherapy	Others

Please make any other comments that you feel are important for Dr. Hoch to know about.