Mensah Medical
Healthcare Reinvented.
www.mensahmedical.com
4355 Weaver Parkway Suite 110, Warrenville, IL 60555 (630) 256-8308

Chart Contact Information Form

Date: _____

Patient Name: Last _____ First _____ Middle Initial_____

DOB: _____/_____/_____ Sex: M or F Home Phone:_____ Cell: _____

Address: City:

State: Zip Code:

Email address:

(If the patient is a minor, please list the email address of the parent or legal guardian).

Occupation: _____ Disabled Retired Student

Employer Phone: (_____)_____

If Patient is a minor: Mother's Name: _____

Father's Name: _____

Legal Guardian: _____

Home Phone: ( ) Cell Phone: ( )

Emergency Contact: _____ Phone: (_____)_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian Other: _____

Guarantor: Last _____ First _____ Middle Initial _____

Guarantor DOB: ____/____/____ Sex: M or F Guarantor Social Security # (last 4 digits): _____

Address: City:

State: Zip Code:

Employer Phone: ( )

Guarantor Occupation: _____ Disabled Retired Student

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HIPAA Authorization Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). By signing this authorization, I permit Mensah Medical, LLC (the "Practice") to use and/or disclose individually identifiable health information (PHI) about my medical history, lab results and outcomes of any therapies provided only under the following conditions:

- with my permission or at my (the patient's) request.
- the purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.
- the Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing information without my consent or participation.

VOICE MAIL MESSAGES: Please initial in the space provided next to each of the following permissions **if you are in agreement**:

I give the Practice permission to leave a medical message on my:

_____ Home voice mail Phone: _____

_____ Work voice mail Phone: _____

_____ Mobile voice mail Phone: _____

If I cannot be reached directly or by voice mail, the Practice may leave a message with my:

_____ Spouse Name: _____ Phone: _____

_____ Parent Name: _____ Phone: _____

_____ Other Name: _____ Phone: _____

Please read and sign here if you agree to the following statement: **If I cannot be reached directly or by voice mail, please do not leave a medical message.**

Signed: _____ Date: _____

EMAIL COMMUNICATION: The Practice cannot send private medical information by email due to privacy concerns. However, the Practice does utilize email communication for appointment reminders and general announcements of new or updated services, programs, research, clinic locations, seminars, and research.

☐ I do not want to receive email communication

☐ I consent to receive email communication as described above.

Print email address (if the patient is a minor, please list the email address of the parent or guardian):

@

Email address is ☐ Self ☐ Parent or Legal Guardian

I do not have to sign this authorization in order to receive treatment from Mensah Medical. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subjected to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Mensah Medical, LLC
4355 Weaver Parkway, Suite 110
Warrenville, IL 60555

Signed by:

Signature of Patient or Legal Guardian | Relationship to Patient

Print Patient's Name | Date

Print Legal Guardian's Name, if applicable

For Office Use Only

Date received by Mensah Medical: _____ Received by: _____

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Permission for Disclosure

PATIENT NAME:

Last _____ First _____ Middle Initial_____

DOB: _____/_____/_____ Sex: M or F

I, _____, give permission to:
(Printed Name of Patient)

_____	_____	_____
(Printed Name of Person)	(Relationship)	(Telephone)
_____	_____	_____
(Printed Name of Person)	(Relationship)	(Telephone)
_____	_____	_____
(Printed Name of Person)	(Relationship)	(Telephone)

to communicate with the staff of Mensah Medical, LLC on my behalf.

Signed by: _____ _____
Signature of Patient or Legal Guardian Date

_____
Print Legal Guardian's Name, if applicable

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Consent for Treatment

I understand that the orthomolecular modality used by Mensah Medical, LLC, utilizes nutrient protocols for treatment.

By signing this form, I agree to participate in this modality with the understanding that even with the highest level of compliance, desired outcomes are not guaranteed and that levels of response may vary.

signed by: _____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Print Patient's Name | Date

_____

Print Legal Guardian's Name, if applicable

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Health History Form

Date:_____

Name:_____ DOB:_____ Sex: M or F

	YES	NO
Significant birth events or traumas:		
Injuries / Head traumas:		
Surgeries:		
Number of Pregnancies:		
Seasonal Allergies		
Food or Chemical Sensitivities		
History of Alcohol Use		
History of Marijuana / Cannabis Use		

PRIMARY DIAGNOSIS:

_____

_____

OTHER DIAGNOSIS:

_____

_____

_____

_____

_____

_____

PRESENT MEDICATIONS

_____

_____

_____

_____

_____

_____

PAST MEDICATIONS

_____

_____

_____

_____

_____

_____

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	Check all that apply to you	SYMPTOMS	Check all known to apply to relatives	Check all that apply to you	SYMPTOMS	Check all known to apply to relatives
1		white spots on nails			delusions	
2		under-achiever			delayed puberty	
3		texture sensitive			dark urine	
4		tantrums			chronic joint pains	
5		strong willed			anxiety	
6		stretch marks			“stitch in the side” pain	
7		pre-mature gray			“night owl”	
8		poor wound healing			ADD / ADHD	
9		poor short term memory			ulcers	
10		poor muscle tone			kidney disease	
11		phobias and fears			diabetes	
12		perfectionist			heart disease	
13		panic			arthritis	
14		pale skin / poor tanning			cancer	
15		odor sensitive			dementia	
16		obsessions			stroke	
17		negative perspective			autism	
18		mood swings			schizophrenia	
19		menstrual irregularity			bipolar disorder	
20		light sensitive			asthma	
21		highly creative			sound sensitive	
22		heart murmur			social isolation	
23		hallucinations			skips breakfast	
24		fruity breath odor			sensitive to loud noise	
25		frequent nausea			ringing in the ears	
26		frequent infections			reading disorder	
27		dry mouth			psoriasis	
28		depression / sadness			eczema	

PHYSICIAN NOTES:

Comments/ Explanations: _____

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Patient Lab Results Mailing Preference

DATE: _____

In an effort to expedite the processing of our patient lab results and completing patient nutrient protocol, Mensah Medical will begin sending results to the patient via email. Patients requesting email results should put programs@mensahmedical.com in their email contact list to avoid the spam filter.

If you would like to receive your results via email instead of by U.S. Post Office mail, please indicate your preference below.

☐ I choose to receive my patient lab results information packet via email.

☐ I prefer to have the patient lab results information packet mailed to me via U.S. Post Office.

Printed Name of Patient: _____

Signed by: _____ _____
Signature of Patient or Legal Guardian Date

_____
Preferred email address

For Office Use Only
Date received by Mensah Medical: _____ Received by: _____