New Paradigm Wellness
30 E Padonia Rd, #305, Timonium, MD 21093
Phone: (410) 560-7404 fax: (443) 705-0228
WayneBonlieMD@me.com

Today's Date: _____

Patient Information

Name: _____

DOB: _____ / _____ / _____

Address:_____

City/Town: _____

State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

How did you hear about us? _____

What are the top three symptoms or problems related to hormones you would like to change?

1. _____

2. _____

3. _____

Please score the two factors below on a scale from 0 - 10.

0 = None or Terrible 10 = High or Excellent

1. My Energy Level _____ 2. My Sense of Well Being _____

Past Medical History

List Medical Conditions both past and current: _____

_____

_____

Surgeries: _____

_____

_____

Medication Allergies: _____

_____

Current Medications: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Supplements and Vitamins: _____

_____

_____

_____

How many hours do you sleep at night: _____

Do you feel rested when you get up in the AM? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How much? _____

Drink Alcohol? ☐ Yes ☐ No How much? _____

Do you exercise? ☐ Yes ☐ No How often? _____

Date of most recent: EKG _____ Stress Test _____ Lipid panel _____
Please bring copy of most recent blood work with you to your appointment

Stress Level: ☐ High ☐ Moderate ☐ Low

Current Stressors: _____

_____

_____

Are you pregnant? ☐ Yes ☐ No

Do you plan to become pregnant in the future? ☐ Yes ☐ No

Date of last menstrual period: _____

Date of menopause: _____

Date of last Pap smear: _____ Name of physician: _____

Date of last Mammogram: _____

Bone Density (DXA scan): _____

Number of pregnancies: _____

Number of Live Births: _____

Number of Miscarriages: _____

PMS: ☐ Mild ☐ Moderate ☐ Severe ☐ NA

Vaginal Complaints: _____

Family History

Uterine Cancer ☐ Yes ☐ No

Ovarian Cancer ☐ Yes ☐ No

Fibrocystic Breasts ☐ Yes ☐ No

Breast Cancer ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No

Colon Cancer ☐ Yes ☐ No

Thyroid problems ☐ Yes ☐ No

Other ☐ Yes ☐ No

Symptom List - *Some of these symptoms will be repeated in different sections because different hormone deficiencies my result in similar symptoms.*

COR

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Poor tolerance to stress	☐	☐	☐	☐	☐
Anxiety with stress	☐	☐	☐	☐	☐
Low Blood Pressure	☐	☐	☐	☐	☐
Tired during the day	☐	☐	☐	☐	☐
Fatigue or mood improved with sweets or sugar	☐	☐	☐	☐	☐
Salt Cravings	☐	☐	☐	☐	☐
Nausea	☐	☐	☐	☐	☐
Inflammatory disease (arthritis etc)	☐	☐	☐	☐	☐
Allergies to foods or medications	☐	☐	☐	☐	☐
Brown spots or increased pigmentation	☐	☐	☐	☐	☐
Eczema, psoriasis or dandruff	☐	☐	☐	☐	☐
Sugar Cravings	☐	☐	☐	☐	☐
Weak or tired when standing	☐	☐	☐	☐	☐
Urinate often	☐	☐	☐	☐	☐

MEL

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Poor Sleep	☐	☐	☐	☐	☐
Difficulty falling asleep	☐	☐	☐	☐	☐
Awakening at night	☐	☐	☐	☐	☐
Excessive pondering of problems at night	☐	☐	☐	☐	☐
Waking up tired	☐	☐	☐	☐	☐

THY

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Sensitive to cold	☐	☐	☐	☐	☐
Cold hands or feet	☐	☐	☐	☐	☐
Generalized fatigue	☐	☐	☐	☐	☐
Fatigue unless exercising	☐	☐	☐	☐	☐
Sleepy during the day	☐	☐	☐	☐	☐
Distracted easily	☐	☐	☐	☐	☐
Poor motivation for tasks	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Water retention	☐	☐	☐	☐	☐
Constant swollen eyelids	☐	☐	☐	☐	☐
Swollen eyes in the AM	☐	☐	☐	☐	☐
Swollen calves/feet	☐	☐	☐	☐	☐
Difficulty losing weight despite dieting	☐	☐	☐	☐	☐

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Constipation	☐	☐	☐	☐	☐
Bedwetting as a child	☐	☐	☐	☐	☐
Slow heart palpitations	☐	☐	☐	☐	☐
Muscle cramps	☐	☐	☐	☐	☐
Carpal tunnel syndrome	☐	☐	☐	☐	☐
Stiff joints in the morning	☐	☐	☐	☐	☐
Joint pain worsens in cold	☐	☐	☐	☐	☐
Hoarse voice in the morning	☐	☐	☐	☐	☐
Dry skin (general/feet or elbows)	☐	☐	☐	☐	☐
Slow growing or brittle nails	☐	☐	☐	☐	☐
Diffuse hair loss	☐	☐	☐	☐	☐
Muscle achiness or soreness	☐	☐	☐	☐	☐
Low body temperature	☐	☐	☐	☐	☐
Diminished sweating	☐	☐	☐	☐	☐
Tingling or numbness in extremities	☐	☐	☐	☐	☐
Decreased hearing	☐	☐	☐	☐	☐
Course skin (rough skin)	☐	☐	☐	☐	☐

E

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Older looking than age	☐	☐	☐	☐	☐
Loss of attention to details	☐	☐	☐	☐	☐
Bleeding gums or poor teeth	☐	☐	☐	☐	☐
Fatigue throughout the day	☐	☐	☐	☐	☐
Poor recovery from exercise	☐	☐	☐	☐	☐
Depressed	☐	☐	☐	☐	☐
Poor memory	☐	☐	☐	☐	☐
Hot flashes	☐	☐	☐	☐	☐
Excessive sweating	☐	☐	☐	☐	☐
Dry eyes	☐	☐	☐	☐	☐
Dry vagina	☐	☐	☐	☐	☐
Pain during intercourse	☐	☐	☐	☐	☐
Pale skin	☐	☐	☐	☐	☐
Wrinkles around eye/ forehead/mouth	☐	☐	☐	☐	☐
New body hair	☐	☐	☐	☐	☐
Drooping breasts	☐	☐	☐	☐	☐
Bladder infections	☐	☐	☐	☐	☐
Urinary incontinence	☐	☐	☐	☐	☐
First menstruation before 12 or after 15	☐	☐	☐	☐	☐
Depression before menstruation	☐	☐	☐	☐	☐

P

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Irritable before menstruation	☐	☐	☐	☐	☐
Swollen breasts before menstruation	☐	☐	☐	☐	☐
Breast cysts	☐	☐	☐	☐	☐
Fibroids of uterus	☐	☐	☐	☐	☐
Endometriosis	☐	☐	☐	☐	☐
General irritability	☐	☐	☐	☐	☐
Generalized anxiety	☐	☐	☐	☐	☐

T

Do you ever have the following symptoms?	No Never	Few Sometimes	Moderate Regularly	Much Often	Always Extreme
Too emotional	☐	☐	☐	☐	☐
Too rigid	☐	☐	☐	☐	☐
Poor strength	☐	☐	☐	☐	☐
Low libido (sex drive)	☐	☐	☐	☐	☐
Difficulty achieving orgasm	☐	☐	☐	☐	☐
Poor muscle tone	☐	☐	☐	☐	☐
Excessive fat	☐	☐	☐	☐	☐
Cellulite	☐	☐	☐	☐	☐
Varicose veins	☐	☐	☐	☐	☐
Hemorrhoids	☐	☐	☐	☐	☐
Bruising easily	☐	☐	☐	☐	☐

Candida Questionnaire Point Score

____ Have you been treated for acne with antibiotics for one month or longer?	50
____ Have you taken antibiotics for any type of infection for more than two consecutive months or shorter courses more than three times in a twelve month period?	50
____ Have you ever taken antibiotics - even for a single course?	6
____ Have you ever had vaginitis?	25
____ Have you ever been pregnant?	5
____ Have you ever taken birth control pills?	15
____ Have you ever taken corticosteroids such as Prednisone, Cortisone, Medrol or dexamethasone?	15
____ When exposed to perfumes, insecticide, other odors or chemicals do you wheezing, burning eyes or other distress?	15
____ Are your symptoms worse on damp, humid days or in moldy places?	20
____ Have you ever had fungal infections such as jock itch, athlete's foot, a nail infection or persistent skin infection that was difficult to treat?	20
____ Do you crave sugar or bread?	20
____ Does tobacco smoke cause you wheezing or burning eyes?	10

Please add your points and record your Total Score _____

Policies and Procedures

In the interests of ensuring a smooth process for patient care, please review the following information.
To maximize the time with the provider, ARRIVE 15 minutes prior to your appointment to take vitals and complete paperwork. Out of respect for all of our patients' time, if a patient is late the visit may be shortened to accommodate subsequent scheduled patients. Longer appointment times are available with the provider (please contact our office for details).

General Office Hours

Monday	9:00 am - 4:00 pm
Tuesday	9:00 am - 4:00 pm
Wednesday	9:00 am - 4:00 pm
Thursday	9:00 am - 4:00 pm
Friday	9:00 am - 4:00 pm

CANCELLATION POLICY: If a patient cancels within 24 hours of the appointment or fails to keep the appointment, there will be a $50 fee.

PATIENT COMPLIANCE: All patients agree to schedule office visits at intervals recommended by the provider who reserves the right to withhold refilling of medications if patients do not follow the recommended office visit/ appointment schedule.

SUBMITTING TO INSURANCE

Although New Paradigm Wellness providers do not participate with any insurance programs patients receive itemized invoices with insurance claim codes for possible reimbursement. Since the providers have opted out of all **Medicare/Tricare** programs, **patients are NOT permitted to submit claims to any Medicare or Tricare** programs for reimbursement.

QUESTIONS FOR THE PROVIDERS: To ensure timely response, questions should be emailed to info@waynebonliemd.com or call the office during regular office hours at 410-560-7404. Please allow 24 hours for a response.

PRESCRIPTION REFILLS: Patients should first contact their pharmacist who will submit a request to our office. Allow 48 hours for all refill requests. **Requests made after 1:00 p.m. on Friday through Sunday may not be reviewed and authorized until Monday.**

SUPPLEMENT ORERS: Our preferred method of receiving supplement orders is via email at info@waynebonliemd.com or at the next visit. Phone orders can be placed during regular office hours Monday through Friday.

I have read, understood and agree to abide by the above policies and procedures. This consent form is valid until all or part is revoked in writing.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date

CONSENT FOR TREATMENT

I request treatment by Wayne Bonlie, MD or designee. I understand that I have the right, as a patient, to be informed about my condition and the recommended treatment to be used so that I can make an informed decision whether or not to undergo the treatment after I have been told both the potential benefits, risks, and hazards involved.

Some treatments used at New Paradigm Wellness are considered "off label" use by the Food and Drug Administration. In the United States, the regulations of the FDA permit physicians to prescribe or use approved medications for other than their intended indications. The practice is known as "off-label use" or "unlabeled uses". Such uses are not indicative of inappropriate usage but are legal and common. To access more information on off-label uses, please visit the FDA's website: www.fda.gov/eder

I agree to comply with any pre-treatment, treatment and post treatment instructions as indicated by the medical provider. I agree to immediately report any adverse reaction or problem to New Paradigm Wellness.

Dr Bonlie will act as primary care only on specific agreement to do so. Many insurance companies do not allow a provider who is not in network to be your primary care provider. Most patients do maintain a separate primary care physician who is in their insurance network. Dr. Bonlie does not have privileges at any hospital and does not do any hospital work.

I understand that New Paradigm Wellness does not accept insurance company payments for possible treatment nor does New Paradigm Wellness coordinate document submission for potential insurance company reimbursement. Any attempt to be reimbursed by an insurance company is solely the patient's responsibility.

Although New Paradigm Wellness is not subject to the Health Insurance Portability and Accountability Act (HIPAA), we follow HIPAA guidelines regarding patient privacy. We will not release your health information without your consent unless subpoenaed by a court of law.

I have read and understand this consent form and agree to its terms. I understand that payments for procedures at New Paradigm Wellness are non-refundable and that it is possible that these procedure treatments may be of little or no help at all. I have had the opportunity to ask any questions about the treatment including: outcomes, risks, complications and alternative therapies. I further understand that New Paradigm Wellness cannot guarantee the results and will not hold its employees responsible for the individual results of the treatment that I have requested. I also understand that any follow-up treatments required will be at my own expense. This consent form is valid until all or part is revoked in writing.

_____

Patient Name (Printed)

_____ _____

Patient Signature Date Provider Signature Date

Payment, Photo, Email and Text Consent Form

Patient Name: _____ Date of Birth:_____

PAYMENT POLICY
I understand that all fees are due at the time of service, unless otherwise specified by the provider.

I understand that there is a 24 hour cancellation policy that I will be charged $50 for either not showing for an appointment or for canceling an appointment within 24 hours of said appointment.

PHOTOS
By checking one of the boxes below I give the provider permission to use my photographs in the following manner:

☐ I only want my photos used in the medical chart

☐ I do not want any photos taken

☐ Unrestricted use of photographs
This may include lectures, before and after pictures, website, etc.

COMMUNICATION VIA EMAIL AND/OR TEXT
By checking the boxes below I consent to communication/notification of the following:

☐ Medical information specified to my medical history, diagnosis, treatments and/or recommendations

☐ Appointment reminders

For Email Notifications enter Email Address:_____

For Text Notifications enter **CELL PHONE #** _____-_____-_____

This consent form is valid until all or part is revoked in writing.

_____ _____ _____
Patient's Name **Signature** (Parent or Guardian if under 18) **Date**

PATIENT INFORMATION & CONSENT

_____ _____ _____
Last Name First Name Date of Birth

_____ _____
Address Apt #

_____ _____ _____
City State Zip Code

_____ _____ _____
Home # Work # Cell #

Name of emergency contact _____Relationship _____ Phone _____

INSURANCE (Please circle one of the following)

Do you have:
Medicare Tricare Neither

The providers have opted out of all Medicare/Tricare programs, patients are NOT permitted to submit claims to any Medicare/Tricare program for reimbursement.

If you checked Medicare or Tricare do you have a secondary insurance? ____ Yes _____ No

HIPAA Acknowledgement

I hereby acknowledge that I have been made aware that the physicians have a privacy policy in place in accordance with the Health Insurance Portability Act of 1996 (HIPAA). As a patient, I acknowledge that the physician or designee has a privacy policy in effect and has made this policy available to me. I am entitled to an additional copy of the privacy policy if I desire.

☐ I authorize the physician or designee to discuss my medical care and treatment with the following people (spouse, children, parent, etc.)

1. _____ 2._____

3. _____ 4. _____

I understand this form is valid until all or part is revoked in writing.

X_____ _____
Patient signature or guardian for the minor patient Date

Costs and Fees:

Bioidentical Hormone Patients

1st Visit:	$250
Follow Up Visits	$150
Lab Testing (Blood):	Varies/Usually covered by insurance
Lab Testing (Saliva):	$150 per kit. Usually done at first or second follow up visit and annually.
Medications:	Varies. The basic estimate for a standard bio-identical hormone cream is approximately $40 per month but may be more.