We would like to welcome you as a new patient to our practice.

Your health is our utmost priority. When it comes to your healthcare, we know you want the best for you and your family. Our mission is to provide quality healthcare to our patients with the most qualified and friendly staff.

PROFILE

Name: ______________________________ Gender: F M Age: ___________

Today's Date: ____/____/______ Date of Birth: ____/____/______

Address: ____

Telephone: ______________________ Cell ______________________ Home

Email Address: ____

Occupation: ____

Marital Status: Single Married

Children/Ages: _______________________

How did you hear about us?

____

May we give you appointment reminder calls? YES NO

EMERGENCY CONTACT:

Name: ____

Telephone: ______________________ Cell ______________________ Home

Relationship: ___________________________

PAST MEDICAL HISTORY

Primary condition you are seeking treatment for: ___________________________________

Date of diagnosis: ____/____/______

TREATMENT REQUIREMENTS

Please confirm you have read and understand the requirements below to receive treatment:

☐ **I understand this is a Patient Funded Treatment**

This is a patient funded treatment and unfortunately cannot be covered by any insurance providers, which will require the patient to pay for the cost of the treatment. The cost will vary depending on the type of treatment, patient's condition(s) and delivery method needed.

☐ **I am able and willing to travel to receive treatment** *(please select all that apply)*

☐ I am able to travel within my state
☐ I am able to travel to surrounding states
☐ I am able to travel inside the U.S.
☐ I am able to travel outside of the U.S.

Describe all symptoms, dates of onset and any other pertinent information:

____
____
____
____
____
____
____
____
____
____
____
____

CONFIDENTIAL

Last Name: ________________________ First Name: ________________________ M.I. _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check the appropriate boxes):

[__] Heart Disease

[__] High Cholesterol

[__] High blood pressure

[__] Low blood pressure

[__] Diabetes

[__] Hypoglycemia

[__] Asthma

[__] Emphysema

[__] Pulmonary Fibrosis

[__] Chronic bronchitis

[__] Hepatitis B

[__] Hepatitis C

[__] HIV

[__] Seasonal allergies

[__] Glaucoma

[__] Seizures

[__] Stroke

[__] Migraines

[__] Depression

[__] Kidney problems

[__] Liver problems

[__] Arthritis

[__] Thyroid problems

[__] Prostate problems

Have you ever been diagnosed with any form of cancer? [__] Yes [__] No

Type: ____________________________________ Date of Diagnosis: ____/____/______

Status: ____

Please describe any current or past medical condition that is not included in the list above:
____

CONFIDENTIAL

Have you ever been hospitalized? [__] Yes [__] No

If yes, what for? ____
____

Please list all past surgeries:

Procedure: ____ Date: ____/____/______

Procedure: ____ Date: ____/____/______

Procedure: ____ Date: ____/____/______

Procedure: ____ Date: ____/____/______
Last Name: _________________________ First Name: _________________________ M.I. _____

Have you ever received a blood transfusion? [__] Yes [__] No | Date: ____/____/______

ALLERGIES AND ADVERSE DRUG REACTIONS
Are you allergic to penicillin or any other drug? [__] Yes [__] No
If yes, please list: ____
____
____

Please list your current medications: ____
____
____

Nutritional supplements / Herbal Preparations: ____________________________________
____
____

SOCIAL AND PREVENTATIVE HISTORY
Do you currently smoke or chew tobacco? [__] Yes [__] No
If yes, how many packs per… (fill out one) Day: _____ **or** Week: _____ **or** Month: ______

If No, Have you in the past? [__] Yes [__] No
If yes, how many packs per… (fill out one) Day: _____ **or** Week: _____ **or** Month: ______

Do you drink alcohol, beer, or wine? [__]Yes [__] No
If yes, how many drinks per… (fill out one) Day: _____ **or** Week: _____ **or** Month: ______

If No, Have you in the past? [__] Yes [__] No

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If yes, how many drinks per… (fill out one) Day: _____ **or** Week: _____ **or** Month: ______

Age: _______________ **Height:** _______________ **Weight:** ___________ **Sex:** ____________

Date of your last medical check-up: ____/____/______

Physician: ____________________________________ **Telephone:** ______________________

Results of your last medical check-up: ____________________________________
Last Name: _____________________ **First Name:** _____________________ **M.I.** ____

Have you ever received a blood transfusion? [__] Yes [__] No | Date: ____/____/______

ALLERGIES AND ADVERSE DRUG REACTIONS

Are you allergic to penicillin or any other drug? [__] Yes [__] No

If yes, please list: ____

____

____

Please list your current medications: ____

____

____

Nutritional supplements / Herbal Preparations: _______________________________________

____

____

SOCIAL AND PREVENTATIVE HISTORY

Do you currently smoke or chew tobacco? [__] Yes [__] No

If yes, how many packs per… (fill out one) **Day**: _____ **or** Week: _____ **or** Month: ______

If No, Have you in the past? [__] Yes [__] No

If yes, how many packs per… (fill out one) Day: _____ **or** Week: _____ **or** Month: ______

Do you drink alcohol, beer, or wine? [__]Yes [__] No

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CONFIDENTIAL

Age: _______________ **Height:** _______________ **Weight:** ___________ **Sex:** ____________

Date of your last medical check-up: ____/____/______

Physician: ____________________________________ **Telephone:** ______________________

Results of your last medical check-up: ____
Last Name: _______________________ **First Name:** _______________________ **M.I.** _____

CONFIDENTIAL