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:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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: _____

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

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: ____/____/_____

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Nutritional supplements / Herbal Preparations: _____

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CONFIDENTIAL MEDICAL HISTORY FORM
American Regenerative Clinic

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. ____