BOTHELL REGENERATIVE MEDICINE

PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PHONE NUMBER: _____ **EMAIL:** _____

ADDRESS: _____

SSN: _____

CHIEF COMPLAINT (Reason for visit): _____

_____

_____

GOALS OF TREATMENT: _____

_____

MEDICATIONS & SUPPLEMENTS (Please list name, dosage and frequency – use back if more room needed):

_____ _____

_____ _____

_____ _____

ALLERGIES: _____

SURGICAL HISTORY (Procedure and Date):

_____

_____

_____

PAST MEDICAL HISTORY (Circle all that apply):

Heart Disease	Kidney Disease	Glaucoma
Hypertension/ High Blood Pressure	Hypo/Hyperthyroidism	Depression
Hypotension/ Low Blood Pressure	Hepatitis	Anxiety
Hyperlipidemia	Ulcers	Migraines
Seizures	Arthritis/ Degenerative Joint Disease	Pancreatitis
Stroke	Anemia	Liver Disease
Diabetes	Tuberculosis	Back/ Joint Pain
Cancer (what kind?)	HIV	
Asthma/ COPD		

BOTHELL REGENERATIVE MEDICINE

FAMILY HISTORY:

	Status	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Migraine	Prostate Cancer	Pancreatitis	Multiple Endocrine Neoplasia 2 (MEN2)	Medullary Thyroid Cancer
Father											
Mother											
Brother/ Sister											
Son/ Daughter											

SOCIAL HISTORY:

Alcohol Use (Please circle): Social History of/ current alcoholism Never Light Daily

Tobacco Use (Please circle): Current user Former user Never

- Packs per day? _____ How many years? _____ Type: _____

Drug Use (Please circle): None Previous use Currently Using What/ How much? _____

Work History (Please circle): Employed Unemployed Disabled Retired

Marital Status (Please circle): Married Widowed Single Divorced/ Separated

JOINT/ MUSCULOSKELETAL PAIN QUESTIONNAIRE (Ignore if no musculoskeletal complaint):

Where is the pain located? _____

On a scale of 0 to 10, what would you rate the pain? _____

Describe the character of your pain – dull/achy, burning, shooting, stabbing/ sharp, cramping, spasming, throbbing, squeezing, tightness _____

Do you have any numbness or tingling? _____

Does the pain radiate? If so, where to? _____

When did the pain begin? _____

Is the pain constant or intermittent? Is it predictable? _____

Is there a time of day that your pain is better or worse? _____

Does anything make the pain better? _____

Does anything make the pain worse? _____

What treatments have you tried? _____

BOTHELL REGENERATIVE MEDICINE

REVIEW OF SYSTEMS (Circle all that apply):

CONSTITUTIONAL:

- Chills
- Fever
- Fatigue
- Unintentional Weight Loss or Gain

HEENT:

- Hearing Loss
- Sinus Pressure
- Visual Changes
- Headaches
- Ear Pain
- Ear Discharge
- Tinnitus

RESPIRATORY:

- Cough
- Asthma
- Hemoptysis
- Shortness of Breath
- Wheezing
- Sputum

CARDIOVASCULAR:

- Chest Pain
- Edema
- Palpitations
- Shortness of Breath While Laying Down
- Heart Murmur
- Hypertension
- DVT/PE

GASTROINTESTINAL:

- Abdominal Pain
- Bloody Stool
- Constipation
- Diarrhea
- Heartburn
- Loss of Appetite
- Nausea
- Vomiting

GENITOURINARY:

- Painful Urination
- Excessive Urination
- Frequency
- Blood in Urine
- Flank Pain
- Incontinence

MALE/ FEMALE REPRODUCTIVE:

- Hernia
- Testicular Masses
- Sexual Dysfunction
- Menstruation Status: _____

MUSCULOSKELETAL:

- Back Pain
- Muscle Pain
- Neck Pain
- Joint Pain
- Joint Swelling
- Recent Trauma or Injury

INTEGUMENTARY:

- Hives
- Rashes
- Itching

NEUROLOGICAL:

- Dizziness
- Numbness or Tingling
- Extremity Weakness
- Migraines
- Seizures
- Tremors
- Loss of Sensation

PSYCHIATRIC:

- Anxiety
- Depression
- Hallucinations

METABOLIC/ ENDOCRINE:

- Cold Intolerance
- Heat Intolerance
- Excessive Hunger or Thirst
- Hair Thinning
- Dry Nails

HEMATOLOGIC/ IMMUNOLOGIC:

- Easy Bruising
- Blood Clots
- Food allergies
- Seasonal allergies

BOTHELL
REGENERATIVE
MEDICINE

BOTHELL REGENERATIVE MEDICINE

Consent to Use or Disclose Health Information

Date_____

I authorize **Bothell Regenerative Medicine** to use and disclose the health and medical information of (name)_____for the purposes of Treatment, Payment and Health Care Operations.*

*__Treatment__ (includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

*__Payment__ (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

*__Health Care Operations__ (includes the necessary administrative and business functions of our office).

You may review **Bothell Regenerative Medicine's** "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Bothell Regenerative Medicine has already used or disclosed the information in reliance on this Consent.

_____

Signature of Patient Date:

_____

Signature of Person Authorized by Law

BOTHELL REGENERATIVE MEDICINE

Consent for Treatment

Patient's name: _____

Address: _____Telephone:_____

If patient is a child, please complete following information:

Mother or Father's name: _____

Address: _____Telephone:_____

I hereby consent to the provision of care, diagnosis and/or treatment by Bothell Regenerative Medicine, and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the care, diagnosis and/or treatment and am not subject to duress or under undue influence.

_____ _____

Signature of Patient or Person Authorized to Consent* Date

Relationship if not patient:

*If this consent is signed by someone other than the patient, it must be signed in the patient's presence.

BOTHELL REGENERATIVE MEDICINE

Office and Financial Policies

Welcome to Bothell Regenerative Medicine (BRM). We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Office and Financial Policies* which we require you to read and sign prior to any treatment.

INSURANCE AND PAYMENTS

I understand that medical insurance plans and policies vary and there may be limitations and exclusions in my plan of which I or BRM may not be aware. I also understand that actual benefits can only be determined by my insurance company. This applies to all medical insurance plans.

I understand that my contract for health insurance is between me and my insurance company. BRM is not a party to that contract. I understand that it is entirely my responsibility to know the benefits and limitations of my insurance plan including effective dates of coverage, deductible, and co-pay/co-insurance due. I agree to be responsible for all charges not covered by my insurance plan. I will notify BRM immediately if there are any changes in my insurance coverage.

Regarding insurance plans where we are a participating provider:
All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Payment for services:
Payment is due in full at the time of service for those without insurance coverage or with insurance plans with which we are out of network.

NO SHOW & LATE CANCELLATION

I understand that if I am late for an appointment then I may need to be rescheduled. I understand that it is my responsibility to know the date and time of my next appointment. If I miss an appointment at the scheduled time, there may be a $50 charge due prior to the next appointment. A missed appointment is defined as one in which there has been no notification of cancellation from the patient at least one full business day prior to scheduled appointment.

MEDICATIONS

I understand that BRM requires three (3) business days advance notice of medication requests and refills.

I have read the *Office and Financial Policy*. I understand and agree to this policy. I also acknowledge the receipt of Bothell Regenerative Medicine *HIPAA Notice of Privacy Practices*.

Patient Name: _____

Signed:_____ Dated: _____