REGEN RX
REGENERATIVE MEDICINE & AESTHETICS

Today's Date: _____ Referred by: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Date of Birth: _____ Age: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Provider: _____ Phone: _____

Are you allergic to Latex? □ Yes □ No

Do you have any allergies or sensitivities? □ Yes □ No If yes, please list: _____

_____

Are you currently taking any medications? □ Yes □ No If yes, please list: _____

_____

_____

Have you experienced any of the following?

High or Low Blood Pressure	□ Yes	□ No	Circulatory problems	□ Yes	□ No
Seizures/Epilepsy	□ Yes	□ No	Fainting or dizzy spells	□ Yes	□ No
Stroke	□ Yes	□ No	DVT/Blood clots	□ Yes	□ No
Hepatitis	□ Yes	□ No	Autoimmune disease	□ Yes	□ No
Hemophilia/bleeding disorder	□ Yes	□ No	Migraine headaches	□ Yes	□ No
Rheumatoid arthritis	□ Yes	□ No	Cancer	□ Yes	□ No
Osteoporosis	□ Yes	□ No	Scleroderma	□ Yes	□ No
Aneurysm	□ Yes	□ No	Complex regional pain syndrome	□ Yes	□ No
Diabetes	□ Yes	□ No	Other: _____		
Hormone Replacement Therapy	□ Yes	□ No	Other: _____		

Lifestyle: Do you smoke, vape, or chew tobacco? □ Yes □ No Recreational drug use? □ Yes □ No

Women only: Are you pregnant, nursing, or planning a pregnancy? □ Yes □ No

Surgical history: _____

_____

To the best of my knowledge, the information on the form is accurate. I understand that providing false information can be dangerous to my health. It is my responsibility to inform Regen Rx of ***any*** changes to my medical history.

Printed Name: _____ **Signature**: _____ **Date**: _____
(patient, parent, or representative)

Cancellation/ Late Arrival Policy: 24-hour notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. Failure to do so will result in the service being charged in full. If you arrive late, your session will be shortened to accommodate appointments that follow yours. Regardless of the length of the treatment, the session will be charged in full.

Signature: _____ **Date**: _____

Liability Policy: Regen Rx is not responsible for any items that you may leave unattended. We strongly recommend leaving expensive, personal items at home, or locked in your care. If you do bring them with you, be sure to gather all items from the treatment room prior to leaving.

Signature: _____ **Date**: _____

Notice of Privacy Practices/HIPAA: In general, any information that is about your health, the health care you receive, or payment for that care is considered confidential under HIPAA compliance statutes and protected by our Company. We may need to use your Protected Health Information to carry out treatment, payment, healthcare operations and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures. The form is found on our website (www.regenrxhealth.com) and is available at our center for you to read and take home with you. By signing below, I acknowledge the receipt of the Notice of Privacy Practices at Regen Rx.

Signature: _____ **Date**: _____

Imaging Policy: If imaging is ordered by one of our providers you may have the imaging performed at the facility of your choice. If you obtain your imaging at Clarion Hospital or a Butler Health System (BHS) facility Dr. Barrett will be able to view your images directly as he is on staff and is credentialed and contracts to provide professional interpretation services at these facilities. If you go to a facility other than Clarion Hospital or a Butler Health System (BHS) site please ask the staff to provide you with a CD copy of your images and bring to your follow up appointment. If your imaging results show anything that needs more urgent attention, we will contact you sooner, otherwise they will be discussed at your follow-up visit. Most facilities also have patient portals to access these reports. If you have any questions about your imaging results prior to a follow-up visit, please call our office.

Signature: _____ **Date**: _____

Reviewed by: _____ **Date**: _____