PATIENT REGISTRATION FORM

10190 Critzer Shop Road, Afton, Virginia 22920
(434) 361-1896

SAVE | PRINT | RESET

PATIENT INFORMATION

Last Name	First Name	M.I.	Date of Birth	Sex	Social Security #

Address	Apt.#	City	State	Country	Zip Code

Occupation	Home Phone	Work Phone	Mobile Phone	Email Address

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name	Spouse's Work Phone:	Spouse's Mobile Phone	Emergency Contact(s)	Emergency Contact Phone(s)

How were you referred to us?

☐ Internet _____
☐ Another Patient (Name): _____
☐ Another Doctor (Name): _____
☐ Other: _____

☐ Our website _____
☐ Another website: _____
☐ Blog: _____

HEALTH HISTORY QUESTIONNAIRE

FAMILY HISTORY — For each member of your family, read down the list and put a check in the boxes that apply. Put one check for each relative having a certain disease, e.g., put 3 checks in Grandparents - Stroke, if 3 of your grandparents suffered strokes. Indicate age only if deceased.

	Father	Mother	Brother(s)	Sister(s)	Spouse	Children	Grandparents	Aunts/Uncles
Age (at death only)								
Cause of Death								
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Allergies / Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Anemia / Blood Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illnesses / Autism	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disease	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism / Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
Venereal Disease	☐	☐	☐	☐	☐	☐	☐	☐
Malaria or Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐

PERSONAL HISTORY

Put a check in the box next to any of the following that you now or have ever had:

☐ Measles	☐ Pancreatitis	☐ Venereal disease	☐ Anxiety	☐ Other:
☐ Mumps	☐ Ulcers	☐ Tuberculosis	☐ Depression	
☐ Chicken pox	☐ Diverticulosis	☐ Concussion/Head injury	☐ Serious injury	
☐ Polio	☐ Hernias	☐ Migraines/Headaches	☐ Alcoholism or Drug Abuse	
☐ Diphtheria	☐ Hemorrhoids	☐ Neurological disorders	☐ Nervous breakdown or Psychosis	
☐ Small pox	☐ Bone/Joint disease	☐ Hay fever	☐ Hyperactivity and/or A.D.D.	
☐ Meningitis	☐ Cancer	☐ Frequent Colds	☐ Heart trouble	
☐ Scarlet fever	☐ Seizures/Epilepsy	☐ Neuritis or Neuralgia	☐ Hypertension/High Blood Pressure	
☐ Rheumatic fever	☐ Serious infection	☐ Sciatica	☐ Stroke	
☐ Genetic disease	☐ Malaria	☐ Low Back Pain	☐ Gall Bladder disease	
☐ Chronic Fatigue	☐ Yellow jaundice	☐ Anemia or Blood disease	☐ Rabies	
☐ Chronic Sinusitis	☐ Liver disease/Hepatitis	☐ Diabetes	☐ Reaction to drugs, vaccines, transfusions	
☐ Bronchitis	☐ Skin disorders	☐ Hormonal disorders	☐ To what?	
☐ Pneumonia	☐ Kidney disease or Stones	☐ Thyroid disease	_____	

MAJOR HOSPITALIZATIONS

If you have ever been hospitalized for any serious illness or operation, write in your most recent hospitalization below. Use the reverse side if needed. (Do not include normal pregnancies)

Year	Operation or illness	Physician's Name	City and State

Please list the name and address of any other physicians who have treated you in the past year and the problem for which you were treated (Do not include visits for cold, flus or other minor acutes).

Physician's Name	Address	Problem

MEDICATIONS

Indicate those medicines you are presently taking or which you have taken in the past. Please give the name and dosage of all current medicines.

Present	Past		Present	Past	
☐	☐	Antibiotics	☐	☐	Diabetes medicines
☐	☐	Pain medicine	☐	☐	Arthritis medicines
☐	☐	Diuretics (water pills)	☐	☐	Diet pills
☐	☐	Sedatives	☐	☐	Antacids or laxatives
☐	☐	Blood pressure medicines	☐	☐	Birth control pills
			☐	☐	Hormones
☐	☐	Heart medicines	☐	☐	Antimalarial drugs
☐	☐	Thyroid medicines	☐	☐	Antituberculosis drugs
☐	☐	Aspirin	☐	☐	Allergy desensitization
☐	☐	Vitamins & Herbs	☐	☐	Other

DRUG ALLERGIES

Please list any and all medicines you are allergic to, e.g., penicillin, sulfa drugs, other antibiotics, aspirin, codeine, etc.

TESTS AND IMMUNIZATIONS

Check those tests and immunizations which you have had. Enter the year when you last were given the tests or shots.

Year		Year		Year	
	☐ Chest X-Ray		☐ Colonoscopy/Sigmoidoscopy		☐ DPT
	☐ Kidney X-Ray		☐ PAP smear		☐ Tetanus
	☐ G.I. Series		☐ Nutritional Analysis		☐ Flu shot
	☐ Colon X-Ray		☐ Polio series		☐ Pneumonia shot
	☐ Electrocardiogram		☐ Measles, mumps, rubella		☐ Other
	☐ TB test		☐ HIV vaccine		
	☐ CT or MRI scan		☐ Ultrasound		

HEALTH FACTORS

Please check those items below that apply:

Yes	No	Do you drink or use?		Yes	No	
☐	☐	Coffee?	__ cups/day	☐	☐	Do you use an electric blanket?
☐	☐	Tea?	__ cups/day	☐	☐	Do you have silver-mercury amalgams in your mouth?
☐	☐	Sodas?	__ cans/day	☐	☐	Do you exercise regularly? If yes, how much?
☐	☐	Beer?	__ cans/day	☐	☐	Do you meditate regularly?
☐	☐	Wine?	__ glasses/day	☐	☐	Do you use "recreational" drugs, e.g. cocaine, LSD, marijuana, etc.?
☐	☐	Other alcohol?	__ glasses/day	☐	☐	Have you any known environmental sensitivities or past or present toxic chemical exposure? If yes, please describe:
☐	☐	Cigarettes?	__ packs/day			
☐	☐	Cigars?	__ cigars/day			
☐	☐	Pipe?	__ bowls/day			
☐	☐	Chew tobacco?				
☐	☐	Snuff?				

Please describe your emotional nature and personality characteristics, especially the major issues in your life.

HEALTH QUESTIONNAIRE

If you have recently been bothered with these problems, check YES.

Yes	No		Yes	No		Yes	No	
☐	☐	frequent or severe headache	☐	☐	recurring indigestion	☐	☐	swollen joints
☐	☐	neck pains	☐	☐	frequent belching	☐	☐	back or shoulder pains
☐	☐	neck lumps or swelling	☐	☐	nausea	☐	☐	weakness in arms or legs
☐	☐	loss of balance	☐	☐	vomiting	☐	☐	painful feet
☐	☐	dizzy spells	☐	☐	pain in abdomen	☐	☐	trembling
☐	☐	blackouts/fainting	☐	☐	bloated abdomen	☐	☐	numbness
☐	☐	wear glasses	☐	☐	constipation	☐	☐	leg cramps
☐	☐	blurry vision	☐	☐	loose bowels	☐	☐	skin problems
☐	☐	eyesight worsening	☐	☐	black stools	☐	☐	scalp problems
☐	☐	see double	☐	☐	gray or whitish stools	☐	☐	itching or burning skin
☐	☐	see halos or lights	☐	☐	pain in rectum	☐	☐	bruise easily
☐	☐	eye pains or itching	☐	☐	itching rectum	☐	☐	nervousness or anxiety
☐	☐	watering eyes	☐	☐	blood in stools	☐	☐	nervous with strangers
☐	☐	hearing difficulties	☐	☐	frequent urination	☐	☐	nail biting
☐	☐	earaches	☐	☐	involuntary escape of urine	☐	☐	difficulty making decisions
☐	☐	running ears	☐	☐	burning on urination	☐	☐	lack of concentration
☐	☐	noises in ears	☐	☐	brown, black or bloody urine	☐	☐	absentminded/loss of memory
☐	☐	dental problems	☐	☐	weak urine stream	☐	☐	lonely or depressed
☐	☐	sore or bleeding gums	☐	☐	difficulty starting urine	☐	☐	frequent crying
☐	☐	sore tongue	☐	☐	constant urge to urinate	☐	☐	hopeless outlook
☐	☐	congested nose	**(MEN ONLY)**			☐	☐	difficulty relaxing
☐	☐	running nose	☐	☐	burning or discharge	☐	☐	worry a lot
☐	☐	sneezing spells	☐	☐	lumps or swelling on testicles	☐	☐	frightening dreams or thoughts
☐	☐	head colds	☐	☐	painful testicles	☐	☐	feeling desperation
☐	☐	nosebleeds	**(WOMAN ONLY)**			☐	☐	shy or sensitive
☐	☐	sore throat	☐	☐	a missed period	☐	☐	dislike criticism
☐	☐	difficulty swallowing	☐	☐	menstrual problems	☐	☐	angered easily
☐	☐	hoarse voice	☐	☐	bleeding between periods	☐	☐	annoyed by little things
☐	☐	wheezing or gasping	☐	☐	tension or pain before periods	☐	☐	family problems
☐	☐	frequent coughing	☐	☐	heavy bleeding	☐	☐	problems at work
☐	☐	cough up phlegm	☐	☐	bearing down feeling	☐	☐	sexual difficulties
☐	☐	cough up blood	☐	☐	vaginal discharge	☐	☐	considered suicide
☐	☐	chest colds	☐	☐	genital irritation	☐	☐	sought psychiatric help
☐	☐	rapid or skipped heartbeats	☐	☐	pain on intercourse	☐	☐	loss or gain in weight
☐	☐	chest pains	☐	☐	swelling or lumps in breasts	☐	☐	often feel warmer or colder than others
☐	☐	shortness of breath with normal activity	☐	☐	painful breasts	☐	☐	loss of appetite
☐	☐	swollen feet or ankles			____ # of pregnancies	☐	☐	always hungry
☐	☐	aching muscles or joints			____ # of births	☐	☐	armpits or groin swelling
					____ miscarriages	☐	☐	unusual fatigue or weariness
					____ premature births	☐	☐	difficulty sleeping
					____ cesareans	☐	☐	fever or chills
					____ abortions	☐	☐	motion sickness
						☐	☐	excessive sweating
						☐	☐	night sweats
						☐	☐	hot flashes

Comments or Special Problems:

10190 Critzer Shop Road, Afton, Virginia 22920
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Contract for Integrative & Regenerative Medical Services

Dear Patient:

Integrative & Regenerative Medicine are distinct, specialized types of medical services apart from allopathic or conventional medical practice. Due to the unique office visit and the extraordinary amount of time and effort required by us to conduct the Integrative & Regenerative Medicine consultation and examination, the charge may not be adequately reimbursed by health insurance.

Please note: We are currently restricted from billing for Integrative & Regenerative Medicine services to Medicare, Medicaid, Blue Cross/Blue Shield and other health insurers. Also, Medicare and Medicaid patients may not receive reimbursement from their insurance coverage.

You will be fully responsible for the payment of all fees at the time that Integrative & Regenerative Medicine services are rendered. An invoice with the appropriate coded billing information will be provided to you for submittal to your insurance company for your reimbursement.

You acknowledge the receipt of and agreement with all of our medical office's policies and fees and information within our Integrative & Regenerative Medicine Practice Information document, including those regulations regarding confirmed consultations that are cancelled and/or missed.

Please sign the following statement, which will serve as an ongoing billing contract for your current and future, Integrative & Regenerative Medicine services.

"I understand that I am responsible for the full payment of all fees for Integrative & Regenerative Medicine consultations at the time that services are provided. Moreover, I will be responsible for all legal fees for any disputes over payment."

Signed:_____ Print Name: _____
Patient, Parent or Guardian

Date:_____

CIRM
CENTER FOR
INTEGRATIVE & REGENERATIVE MEDICINE

10190 Critzer Shop Road, Afton, Virginia 22920
(434) 361-1896
Fax (540) 456-6161
www.cirm1.org

Patient Acknowledgement of Receipt/Review of the Notice of Privacy Practices

PATIENT NAME: _____

By signing this form, I am acknowledging my receipt and/or review of the posted Notice of Privacy Practices of the Center for Integrative & Regenerative Medicine.

I have been given the right to review the Notice of Privacy Practices prior to signing this form.

Signature of Patient or Legal Guardian ***Please be aware that typing in your name is a legal e-signature and is enforceable as a handwritten signature.***	Print Name of Legal Guardian (if applicable)
Print Name of Patient	Date

Please kindly complete and return the Patient Registration Form to:
info@cirm1.org or fax to: 540-456-6161

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POLICIES & FEES

PLEASE NOTE:

1) A 50% deposit is required for all new office or phone consultations. This is collected at the time that the appointment is scheduled.
2) If your new appointment is cancelled within 72 hours in advance, then the deposit for your initial consultation is refundable minus an administrative fee of $50.00. If your new appointment is cancelled after 72 hours prior to the scheduled date, then the deposit for your initial consultation is forfeited.
3) Changes to any confirmed, scheduled, follow-up office and phone consultations must be made 48 hours or more prior to the appointment. Follow-up office and phone consultations that are missed without prior notice being received by our staff will be charged an administrative fee of 75% of the appointment fee.
4) For Tuesday appointments, the cancellation notice must be received on the prior Thursday.
5) In the event of inclement weather, if you choose not to come to the office, then your confirmed, scheduled consultation will be provided via telephone. If you decline this service, you will be charged an administrative fee of 75% of the appointment fee.

Fee Schedule

Initial, 1 hour Integrative Medicine consultation is $450.00
2½ hour Constitutional Homeopathic Medical consultation is $995.00
Follow-up consultations are $150.00 (½ hour or less as needed)
An additional charge of $50.00 per ¼ hour will apply for a follow-up consultation over ½ hour
Additional fees will apply for IV Therapies, Joint Regeneration Therapy, Peptide Therapy, Stem Cell Therapy, special laboratory testing, medications and/or supplements

Billing

Payment is due in full at the time that services are provided. We do not bill patients or insurance companies. You will be given a super-bill with all fees and pertinent coding. You will need to contact your insurance company and ask how they would like you to submit the super-bill for reimbursement directly to you. You are responsible for all legal fees related to debt collection.

Medicare & Other Insurance Coverage

Medicare does not cover alternative and complementary medicine, including Homeopathy, Naturopathy, IV therapies, specialized testing, supplements, etc. As a result, our office cannot and does not accept Medicare insurance. Most private insurance companies tend to follow Medicare policies and will also not cover alternative, complementary medical services. You will need to read your insurance policy very carefully and be familiar with its terms and conditions.

Phone Calls

We realize that your phone calls are an important part of our service to you. We will make every effort to return your call as soon as possible. However, we are a very busy medical office, and if you do not hear from us, please call back.
'After-hours medical care' phone consultation services will be charged a minimum of $50.00 after the initial, free, three minutes.

Your signature is required as acknowledgment of your receipt of our office policies & fees:

Name: _____ Date:_____