**Confidential New Patient Information**

**Date:** ______________

Last name: ____________________________ First name: ____________________________ MI: ______________

SSN#_____-_____-______ DOB: ___/___/______ Age: ____ Sex: ____ Relationship Status: _________________

Home address: ________________________________________________________________________________

City: __________________________________ State: _______________ ZIP: ____________________

Home phone# (_____) _____-________ Work# (_____) _____-________ Mob# (_____) _____-_______

Occupation: ________________________________ Employer/School: _________________________________

Preferred Pharmacy: _______________________________ Pharmacy Phone#: (____) ____-_____________

Email address: ______________________________________________@_________________________________

Language preferred: _____________________________ Race/Ethnicity: _________________________________

Preferred mode to receive billing statements: ☐ By Mail ☐ E-bill

**Emergency contact details**

1. Last name: ____________________________ First name: ___________________ Relationship: __________

Home phone# (_____) _____-________ Work# (_____) _____-________ Mob# (_____) _____-_______

2. Last name: ____________________________ First name: ___________________ Relationship: __________

Home phone# (_____) _____-________ Work# (_____) _____-________ Mob# (_____) _____-_______

**Insurance details**

Primary insurance name: _____________________________________ Policy# _______________________

Secondary insurance name: ___________________________________ Policy# _______________________

Main reason for today's visit:

__________________________________________________________________________________________

Other concerns:

__________________________________________________________________________________________

| **Physicians who care for you:** | **Specialty:** | **Phone#:** |
|---|---|---|
| | | |
| | | |

**ALLERGIES:**

| |
|---|
| |
| |
| |

**MEDICATIONS: Please list all medications, supplements, vitamins or herbs you have taken within the last month**

| Medication: | Dose |
|---|---|
| | |
| | |
| | |
| | |
| | |
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| | |
| | |
| | |

**IMMUNIZATION HISTORY:**

**Immunizations and most recent date:**

| | | | |
|---|---|---|---|
| Chickenpox | Date: ______________ | MMR (Measles, Mumps, Rubella) | Date: ______________ |
| Flu Shot | Date: ______________ | Pneumonia | Date: ______________ |
| Gardasil/HPV/Cervical | Date: ______________ | Tdap (Tetanus and pertussis) | Date: ______________ |
| Hepatitis A | Date: ______________ | Tetanus | Date: ______________ |
| Hepatitis B | Date: ______________ | Zostavax (Shingles) | Date: ______________ |
| Meningococcus | Date: ______________ | Other | Date: ______________ |

**(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY**

Last PAP Smear
Date ___________________ Abnormal
Last Mammogram
Date ____________________ Abnormal
Age of first menstrual period: __________________
Date of last menstrual period
or age of menopause: ________________________
Number of pregnancies: ______________________
births: _____miscarriages: _____abortions: _____
Cesarean sections If yes, then number: _________

Bleeding between periods
Heavy periods
Extreme menstrual pain
Vaginal itching, burning, or discharge
Wake in the night to go to the bathroom
Hot flashes
Breast lump or nipple discharge
Painful intercourse
Sexually active
Current sexual partner is Female Male
Do you use condoms Yes No

Other Birth control method used:
_____________________________________________
Interested in being screened for STD's

**PAST MEDICAL HISTORY**

**Please check all that apply:**

Anxiety Disorder
Arthritis
Asthma
Bleeding Disorder
Blood Clots (or DVT)
Cancer (type_____________)
Coronary Artery Disease
Claustrophobic
Diabetes – Insulin
Diabetes - Non-Insulin
Dialysis
Diverticulitis
Fibromyalgia
Gout
Pacemaker
Heart Attack
Heart Murmur
Hiatal Hernia or Reflux Disease
HIV or AIDS
High Cholesterol
High Blood Pressure
Thyroid
Kidney Disease
Kidney Stones
Leg/Foot Ulcers
Liver Disease
Osteoporosis
Polio
Pulmonary Embolism
Reflux or Ulcers
Stroke
Tuberculosis
Other: ______________________

**PAST SURGICAL HISTORY**

| Procedure: | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**FAMILY HEALTH HISTORY**

| RELATION | ALIVE? | AGE | SIGNIFICANT HEALTH PROBLEMS |
|---|---|---|---|
| Grandmother(maternal) | Y/N | _____ | Alcoholism Arthritis Depression Cancer Diabetes Stroke Heart disease Hypertension Osteoporosis Genetic disease |
| Grandfather(maternal) | Y/N | _____ | Alcoholism Arthritis Depression Cancer Diabetes Stroke Heart disease Hypertension Osteoporosis Genetic disease |
| Grandmother(paternal) | Y/N | _____ | Alcoholism Arthritis Depression Cancer Diabetes Stroke Heart disease Hypertension Osteoporosis Genetic disease |
| Grandfather(paternal) | Y/N | _____ | Alcoholism Arthritis Depression Cancer Diabetes Stroke Heart disease Hypertension Osteoporosis Genetic disease |
| Father | Y/N | _____ | Alcoholism Arthritis Depression Cancer Diabetes Stroke Heart disease Hypertension Osteoporosis Genetic disease |
| Mother | Y/N | _____ | Alcoholism Arthritis Depression Cancer Diabetes Stroke Heart disease Hypertension Osteoporosis Genetic disease |
| Brother/Sister | Y/N | _____ | Alcoholism Arthritis Depression Cancer Diabetes Stroke Heart disease Hypertension Osteoporosis Genetic disease |

Brother/Sister Y/N _____ Alcoholism Arthritis Depression Cancer Diabetes Stroke Heart disease Hypertension Osteoporosis Genetic disease

Other: ______ Y/N _____ Alcoholism Arthritis Depression Cancer Diabetes Stroke Heart disease Hypertension Osteoporosis Genetic disease

**SOCIAL HISTORY**

**Education**

Less than 8th grade
High school
2-year college
4-year college
Postgraduate

**Caffeine**

None
Occasional
Moderate
Heavy
# of cups/cans per day? ____

**Tobacco**

Do you use tobacco? Yes No
If not currently, did you ever use tobacco?
Yes No
Cigarettes -____pks. /day
Chew - ____/day
Cigars - _____/day
# of years____
Or year quit __________

**Marital Status**

Married
Single
Divorced
Separated
Widowed
Domestic partner

**Alcohol**

Do you drink alcohol? Yes No
If so, how often?
Occasionally ___________________
< 3 times a week
> 3 times a week
How many drinks per week?

**Drugs**

Do you currently use recreational or street drugs? Yes No
If yes, list: __________________________
____________________________________
____________________________________
____________________________________

**Sleep** Hours of sleep _______
Difficulty staying asleep? Yes No
Difficulty falling asleep? Yes No
Waking up fresh? Yes No

## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this is a primary care doctor referring you to a specialist doctor.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.
- We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
- We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if you’re unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of ________________________ and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer Nancy Martinez for more information, in person or in writing.

**Receipt of Notice of Privacy Practices written acknowledgement form**

I am a patient of ________________________________. I hereby acknowledge receipt of RMG's Notice of Privacy Practices.

Signature: _____________________________________

Date: _________________________________________

OR

I am a parent or legal guardian of ______________________ [patient name]. I hereby acknowledge receipt of RMG's Notice of Privacy Practices with respect to the patient.

Parent/Spouse/Guardian name: ________________________

Relationship to Patient: _______ Parent_______ Legal Guardian_______ Spouse

Signature: __________________________

Date: ______________________________

**Authorization/Financial Responsibility Agreement**

Your signature is required in order that we may process all insurance claims and to ensure payment of services rendered by **Regenerative Medical Group**. Please read carefully before signing.

- I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the rendering physician/group, and I authorize payment directly to him/her. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
- I authorize the release of medical information necessary to my insurance company to process claims and to receive the reimbursement
- (If you do not wish diagnosis information released, please notify the front office and note that this may affect your insurance coverage and you may be responsible to pay for the visit)
- I understand that if I receive any payments due to the doctor, it is my responsibility/obligation to immediately remit the payments to the rendering physician/group. I further realize that if I fail to do so, I am responsible for the bill in its entirely.
- If my insurance benefits are cancelled, and I continue to receive services, I agree to pay all bills in full
- I also agree to cooperate with my insurance company in submitting all forms they request. Should I fail to do so, and thus payment is denied, I agree to pay the bills in its entirely.
- I also permit that a copy of this authorization be used in place of the original. This authorization is in effect until I choose to revoke it.
- INSURANCE COVERAGE does not necessarily mean FULL coverage, and I understand that I am responsible for all co-insurances, co-payments and deductibles
- I/We further agree that the account may be placed for collection when it becomes 60 days past due.

I hereby acknowledge that: I have read the above or have had the above read to me and that I understand the terms of this agreement.

Patient's signature: ___________________ Date: _________________

## Authorization for Use and Disclosure of Medical Information

This authorization allows the healthcare provider(s) named below to release confidential medical information and reports.

I hereby authorize: ________________________________________________________________

________________________________________________________________

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and or medical records by means of mail, Fax, or other electronic methods.

To: Regenerative Medical Group
615 E Chapman Ave, Orange CA 92866
**If chart exceeds 30 pages, please mail**

I authorize that my payments of benefits from my insurance be paid on my behalf to the provider.

Dr. Bryn J. Henderson, DO, JD, CPE, CIME    Byounghi (Ann) Lee, FNP

To authorization shall be effective now and remain in effect until: ______________________

____________________________________    __________________________
Signature of patient (or legal guardian)    Date of birth

____________________________________    __________________________
Patient's Name (PRINT)    Date

## Cancellation Policy/No show Policy

**1. Cancellation**
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

**If an appointment is not cancelled at least 24 hours in advanced, you will be charged a forty ($40) fee for all appointments. Please note that this will not be covered by your insurance company**

**2. Scheduled appointments**
We understand delays can happen; however, we must try to keep the other patients and doctors on time.

**If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.**

**3. No Show for Doctors Appointment's (includes IV therapies and Neurofeedback)**
Due to full appointment book, last minute no shows can cause problems such as preventing other patients from getting treatment needed and or added expenses for the office and/or brain tuner.

**If you are unable to give a 24-hour notice and do not show up for your appointment's, there will be a forty ($40) no show fee. Please not that this fee will not be covered by your insurance company**

**______________________    ____________________________    ___________**
**Print Patient Name    Signature Patient/ Guardian    Date**