DALLAS FAMILY MEDICAL AESTHETICS • JULIE L. REIHSEN, M.D.
16901 N. DALLAS PKWY, SUITE 208 • ADDISON, TX 75001 | O: (972) 248-2020 • F: (972) 248-2028

PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name:____________________________________ Last Name:____________________________________ MI: ________ | SEX ☐ M ☐ F

AGE_______ | Date Of Birth _____________ | SSN _____-______-_____ | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: ____ Apt# ____________ City _______________ State _____ Zip ________

Home Number (_______)_______-_______ | Cell Number (_______)_______-_______ | Business Number (_______)_______-_______

Employer Address: ____ Ste# ____________ City _______________ State _____ Zip ________

Emergency Contact: ____________________________________ Relation:____________________ | Contact No. (______)_______-_______

INSURANCE INFORMATION

Responsible Person | First Name:_____________________ Last Name:________________________ MI: ______ SSN _____-______-_____

Relation to Patient: ____ | Date of Birth _____________

Address: ____ Apt# ____________ City _______________ State _____ Zip ________

Person Responsible Employed By: ____

Employer Address: ____ Ste# ____________ City _______________ State _____ Zip ________

Insurance Address: _______________________________________ Ste# ____________ City _______________ State _____ Zip ________

ID Number: ____ | Group Number: __________________________________

Secondary Insurance (if any): ____ | Phone Number: __________________________________

Insurance Address: _______________________________________ Ste# ____________ City _______________ State _____ Zip ________

ID Number: ____ | Group Number: __________________________________

CONTACT POLICY

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by an alternative means. Please let us know how you prefer to be contacted.

1. Home Number ☐ OK to leave detailed information ☐ Leave call back number only
2. Cell Number ☐ OK to leave detailed information ☐ Leave call back number only
3. Work Number ☐ OK to leave detailed information ☐ Leave call back number only

We will also send reminders for future appointments or recall for physicals or well woman examinations by text, please provide cell number
Cell Phone Number: ____

We would like to inform you of our services and informational meetings. If you would like to receive this information, please provide email
Email: ____ @ ______________________________.____________

_______________________________________ _______________________________________ ____________________________________
Signature of Beneficiary, Guardian or Personal Representative | Printed Name and Relationship to Patient (if not beneficiary) | Date

ASSIGNMENTS OF BENEFITS

I hereby assign to Julie L. Reihsen, M.D., P.A. any insurance or other third-party benefits available for health care services provided to me. I understand that Julie L. Reihsen, M.D., P.A., has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Julie L. Reihsen, M.D., P.A., I agree to forward to Julie L. Reihsen, M.D., P.A. all health insurance and any third-party payments that I receive for services rendered to me immediately.

_______________________________________ _______________________________________ ____________________________________
Signature of Beneficiary, Guardian or Personal Representative | Printed Name and Relationship to Patient (if not beneficiary) | Date

RELEASE OF INFORMATION

I authorize Julie l. Reihsen, M.D., P.A. to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV, or other communicable diseases) requested by my health insurance company, Medicare or any other third-party payers. I authorize Julie L. Reihsen, M.D., P.A. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Julie L. Reihsen. M.D., P.A. I agree that provisions will remain in effect until I provide written revocation to Julie L. Reihsen, M.D., P.A.

_______________________________________ _______________________________________ ____________________________________
Signature of Beneficiary, Guardian or Personal Representative | Printed Name and Relationship to Patient (if not beneficiary) | Date

DALLAS FAMILY MEDICAL AND AESTHETICS

Patient Name: ____ Date:________________________

Age:________ DOB:____________ Height:____________ Weight:____________________

What area(s) of improvement are you interested in?____

____

List any ED medications you are currently taking or have used in the past: ____

Did they work?:____

List any conditions/medical history you currently have or have had in the past:

List any known allergies: ____

When was the last time you saw a doctor for a physical exam? ____

List all medications and supplements you are currently taking:

Medications	Supplements

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omission that I may have made in the completion of this form.

Signature:_____________________________ Date:________________

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16901 Dallas Parkway, Suite 208 | Addison, TX 75001

DALLAS FAMILY MEDICAL AND AESTHETICS

Patient Name:____Patient DOB:_______________

Email:____Phone Number:__________________________

Date:____________________________

The Erectile Hardness Score [*circle one*]

1. Penis is larger, but not hard
2. Penis is hard, but not hard enough for penetration
3. Penis is hard enough for penetration, but not completely hard
4. Penis is completely hard and fully rigid

SHIM

1. How would you rate your confidence that you can get and keep an erection? ______
1=very low 2=low 3=moderate 4=high 5=very high

2. When you have erections with sexual stimulation how often are your erections hard enough for penetration?
1=never 2=a few times 3=sometimes 4=most times 5=always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?
1=never 2=a few times 3=sometimes 4=most times 5=always

4. During sexual intercourse, how difficult is it to maintain your erection to completion of intercourse? ________
1=extremely difficult 2=very difficult 3=difficult 4=slightly difficult 5=not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you? ______
1=never 2=a few times 3=sometimes 4=most times 5=always

For office use only:

Results:

Erectile Hardness Score___________

SHIM Total Score ________________

1-7 Severe ED 8-11 Moderate ED 12-16 Mild moderate ED 17-21 Mild ED 22-25 No ED

Recommended Therapy:

Wave Therapy:____

Priapus Shot:____

Affirm:____

Pump:____

Provider Init:_____________

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GAINSWave®

Pre - Treatment Instruction

Please read carefully and follow instructions before your treatments.

• Notify your GAINSWave provider if you have

- Coagulation disorder
- History of thrombosis
- Are on blood thinners (anticoagulants)
- History of cancer – especially prostate or penile cancer
- Active or recent infection
- Active or recent sexually transmitted infection
- Lesions or sores on or near treatment area
- Penile implant

• Trim or shave treatment areas for ease of treatment for both you and provider

• If using numbing cream, note that numbness may remain for 4-5 hours after procedure

• For best results discontinue use of anti-inflammatory agents 2 weeks prior to treatment; these include but are not limited to:

- Aspirin (ASA)
- NSAIDs (Motrin, ibuprofen, Aleve, Advil, etc.)
- Essential fatty acids (EPA, DHA)
- Vitamin A
- Turmeric
- Garlic
- Ginger
- Cayenne Pepper
- **Tylenol is okay to use during this recommended period