Juventas Plasma LLC
1920 Corporate Drive Suite 101A
San Marcos, Texas 78666

Patient Registration Information

A copy of your drivers' license is also needed for your chart. It is the patients' responsibility to keep personal (name, address, and phone number) information current with our office. Thank you!

Date: _____ **How did you hear about us:**_____

Last Name _____ First Name _____Middle _____

Address _____ Apt # ____ City _____ State_____ Zip _____

DOB _____ Sex: M F SSN _____ Marital Status _____

Race_____ Ethnicity_____ Language: English Spanish Other_____

Driver's License # _____ EXP _____

Home # _____ WK # _____ Cell # _____

Email Address _____ Employed By _____

Emergency Contact
You consent for us to contact this person in the event of an emergency.

Name _____ Relation to Patient _____ Phone # _____

Address _____Apt #_____City _____ State _____ Zip _____

Advance Directives
Do you have a Living Will? _____ If yes, please list the location of the Living Will or contact person

_____.
A copy is also recommended for your chart, if over age 65.

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received/read this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

I do _____ I do not _____ authorize Juventas to leave a message with available persons at my home _____, work _____, cell _____ phone number, on my answering machine, or with the emergency listed above.

Patient Name: _____ Patient Date of Birth: _____
(Please Print Name)

SIGNATURES: Patient/Legal Representative: _____ *Date*: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

Turn over to complete patient registration. Thank you!

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Patient Name: _____ DOB: _____ Date: _____

Medical History Form

	Patient	Mother	Father	Brother/ Sister	Grandmother Father side	Grandfather Father side	Grandmother Mother side	Grandfather Mother side
Allergies								
Arrhythmia								
Asthma								
Carotid Artery Stenosis								
Congestive Heart Failure								
COPD								
Coronary Artery Disease								
Diabetes								
GERD								
Headaches, Migraines								
Hyperlipidemia								
Hypertension								
Hypothyroidism								
Iron Deficiency, Anemia								
Obesity								
Osteoarthritis								
Osteoporosis								
Peptic Ulcer								
Cancer: _____								
Other: _____								
Other: _____								

Medications

Drug	Dosage	Directions

Please List Any Allergies Below

Allergen	Reaction	Onset

Phone: (512) 667-9247 Fax: (512) 667-7799

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Patient Name: _____ DOB: _____ Date: _____

Surgeries

Reason	Date

Hospitalizations

Reason	Date

Do you currently smoke? Y / N

Have you ever had a blood product infusion? Y / N

If yes have you ever had a reaction to a blood product infusion? Y / N
What was your reaction: _____

Have you ever had:

Atrial Fibrillation Yes / No

Kidney Problems Yes / No

IgA deficiency Yes / No

Any other Cardiovascular issues: _____