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Regenerative Therapies for Active Life

Patient Demographics

Today 's Date :_____/_____/________

Patient Legal Name:____DOB:_____/______/_______Account #: ____________________
First Name Last Name

Age: ________ Patient SSN:______-________-________ Gender: ❑ Male ❑ Female

Physical Address: ____
Address City State Zip

Home Phone: ____ Cell Phone:____

Work Phone: ___________________________________ Email:____

Billing Address:____
Address City State Zip

R esponsible Party Demographic Information Same as above ❑

Patient's Relationship to Responsible Party: ❑ Self ❑ Child ❑ Spouse ❑ Guardian ❑ Other:____________________________

Name of Responsible Party:____Gender: ❑ Male ❑ Female

Mailing Address:____
P.O. Box City State Zip

Billing Address:____
P.O. Box City State Zip

Same as above ❑

DOB:_______/_______/__________ SSN:________-______-_________

AMEX VISA MASTERCARD

Acct. #____
Exp. Date________/____________
CID_________________

I hereby authorize payment directly to BHDRxSportsMedicine DBA Aesthetique Laser Institute, Inc. for medical services rendered. I authorize the release of my medical information deemed necessary in the processing of a claim. It is my understanding that I am financially responsible for this amount, regardless of insurance coverage.

I have received a copy of Beverly Hills DRx Sports Medicine's Privacy Policy.
I hereby consent to historical, physical, laboratory examinations, and diagnostic imaging as deemed necessary by Dr. McBeth

Date:________/________/__________ Signature:____

Additional Patient Information

Student: ❒ Yes ❒ No If yes, name of school: ____

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

Patient Employer:______________________ Spouse Employed: ❒ Yes ❒ No Employer:____________________

Who referred you to us?___________________________State:______________________________________

Who is your family physician?______________________City:_______________ Phone:_________________

Emergency Contact Information

Name:_________________________________ City:____

Cell Phone:______________________________ Home Phone: ___________________________________

Work Phone:_____________________________ Relationship to Patient: ____________________________

Would you like to permit this person to receive information regarding medical and/or billing questions? Yes No

Pharmacy Information

Preferred Pharmacy Name:_________________________________ Address: __________________________

City: ______________________ State: _________Zip: ___________ Phone: __________________________

____

❒ I agree to receive future email correspondence to this email address:____________________________

❒ I agree to receive future SMS/Text messages to this number (messaging charges may apply if your cell phone rate plan does not include SMS/text messages): ______-________-_______

Date: _______/_____/_________Print Name: __________________________ Signature ______________________

HIPAA - NOTICE OF PRIVACY PRACTICES

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will securely store your medical information on a computer for use as part of rendering patient care. For example, your medical information may be used by the health care professional treating you, by the business office to process your payment for the services rendered and by the administrative personnel reviewing the quality and appropriateness of the care you receive.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination or the office's compliance with relevant laws.
- Unless you object, we will include general information, including your name, location in the clinic, your condition described in general terms and your religious affiliation in a directory of individuals located in the clinic. The directory information, except for your religious affiliation, will be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name.
- Unless you object, we may disclose to family members, other relatives or close personal friend the medical information directly relevant to such person's involvement with your care.
- Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.
- We may disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.
- We may use or disclose your information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.
- We may disclose your medical information in the course or certain judicial or administrative proceedings. We may disclose your medical information for law enforcement purposes or other specialized government functions
- We may disclose your medical information to a coroner, medical examiner or a funeral director.
- If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization
- We may disclose your medical information for certain research purposes.
- We may use or disclose your medical information to prevent or lessen a serious threat to health or safety or another person or the public.
- We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:
You have the following rights with respect to your medical information.

- The right to request restrictions on certain uses and disclosures of your medical information. We are not required to agree to your requested restriction, but if we do, we will honor it.
- The right to receive communications from us in a confidential manner.
- The right to inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- The right to request an amendment of your medical information. We may deny your request for certain specific reasons, and, if denied, we will provide you with a written explanation for the denial and information regarding further rights you would have at that point.
- The right to receive an accounting of the disclosures of your medical information made by the clinic in the six years prior to your request, except for disclosures for treatment, payment or clinic operational purposes, and for other certain specifications disclosure types.
- The right to request a paper copy of this notice of Privacy Practices for Protected Health Information.
- The right to complain to the clinic and/or to the United States Department of Health and Human Services if you believe that the Hospital has violated your privacy rights. To complain to the clinic, please contact: The Administrative Department of the clinic in question. If you choose to file a complaint you will not retaliated against in any way.

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Date ______/_______/__________

Signature____

History & Physical Form

Name:____DOB:______/_____/________ Age:________Date:_______/_______/_____

Side: ❑ Left ❑ Right

☼ Neck
☼ Shoulder
☼ Back
☼ Elbow
☼ Hip
☼ Wrist
☼ Hand
☼ Fingers
☼ Knee
☼ Ankle
☼ Foot
☼ Toes

Pain Frequency		Pain Level	
❑	0		0
❑	1	❑	1
❑	2	❑	2
❑	3	❑	3
❑	4	❑	4
❑	5	❑	5
❑	6	❑	6
❑	7	❑	7
❑	8	❑	8
❑	9	❑	9
❑	10	❑	10

Height:_____________ Weight: _____________ Who referred you to us?____

How long have you had the pain? __________________________ Is the pain resulting from an injury? ❑ Yes ❑ No

If an injury, please provide date of injury and describe how you were injured or what type of problems you are having now.

______/_______/______ ____

____

____

Have you been treated previously by another doctor for this body part? ❑ Yes ❑ No

*If yes, please bring any X-Rays, MRI Films, or any other Medical Records that may be pertinent to this visit

Any previous problems or injuries? ❑ Yes ❑ No If yes please describe____

____

Physician: ___________________________ Hospital: ____________________________ City: _______________ State:_____________

Is this a Work injury? ❑ Yes ❑ No If so, is Worker's Comp involved? ❑ Yes ❑ No

Is this a Sports injury? ❑ Yes ❑ No If so, what level do you play? ❑ Recreational ❑ Junior/High School ❑ College ❑ Professional

Check ANY previous treatments and/or testing for this injury?

❑ X-rays ❑ CT Scans ❑ MRI ❑ Physical Therapy ❑ Injections ❑ Surgery
❑ Medications ❑ Chiropractor ❑ Acupuncture

Have you consulted or retained an attorney regarding this injury? ❑ Yes ❑ No

Current Medical History

Past Medical History

- ❒ Anemia
- ❒ Asthma
- ❒ Bleeding/Hematology DZ
- ❒ Blood Clots
- ❒ Cancer
- ❒ Cardiac History
- ❒ Gout
- ❒ High Cholosterol
- ❒ HIV / AIDS
- ❒ Hypertension
- ❒ Kidney Disorders
- ❒ Liver, Stomach, Bowel Disease
- ❒ Osteoarthritis
- ❒ Osteoporosis
- ❒ Rheumatoid Arthritis
- ❒ Thyroid Disorders
- ❒ Other

Past Medical History Continued:

Have you ever had a reaction to anesthesia? ❒ Yes ❒ No

Do you have a pacemaker? ❒ Yes ❒ No

Past hospitalizations (NOT for surgery) ❒ None________________________________

____

____

____

____

What past operations have you had? When? ❒ None__________________________

____

REVIEW OF SYSTEMS — Please check all that apply

CONSTITUTIONAL
- ❒ Fever
- ❒ Decrease in Appetite

EYE
- ❒ Blurry Vision
- ❒ Vision Problem

CARDIOVASCULAR
- ❒ Chest Pain
- ❒ Heart Disease
- ❒ Hypertension

RESPIRATORY
- ❒ Chronic Cough
- ❒ Shortness of Breath
- ❒ Wheezing

GASTROINTESTINAL
- ❒ Heartburn
- ❒ Nausea
- ❒ Vomiting
- ❒ Hepatitis

GENITOURINARY
- ❒ Dysuria
- ❒ Renal Disorders

HEME / LYMPH
- ❒ Easy Bruising
- ❒ Anemia
- ❒ HIV Infection

ENDOCRINE
- ❒ Thyroid Disorders
- ❒ Diabetes Mellitus

SKIN
- ❒ Skin Rash
- ❒ Skin Lesions

NEURO
- ❒ Headache
- ❒ Dizziness
- ❒ Seizures

MUSCULOSKELETAL
- ❒ Joint Stiffness
- ❒ Diabetes Mellitus
- ❒ Osteoporosis
- ❒ Joint Swelling
- ❒ Upper Back Pain
- ❒ Lower Back Pain
- ❒ Gout
- ❒ Rheumatoid Arthritis
- ❒ Ankle Joint Swelling

PSYCH
- ❒ Depression
- ❒ Alcohol Use
- ❒ Drug Use

SOCIAL HISTORY - Please check all that apply

WORK
- ❒ Working Full Time
- ❒ Working Part Time
- ❒ Currently on disability
- ❒ Not working

LIVING SITUATION
- ❒ Live with spouse
- ❒ Independently alone
- ❒ Living in a nursing home

Alcohol History
- ❒ Never Drank Alcohol
- ❒ Being a Social Drinker
- ❒ Heavy Alcohol Consumption

TOBACCO
- ❒ Previous Smoker
- ❒ Chew Tobacco
- ❒ Smoking Cigarettes

DRUG USE- PRIVATE INFORMATION
- ❒ Marijuana
- ❒ Cocaine
- ❒ Intravenous Drugs

MARITAL STATUS
- ❒ Currently Married
- ❒ Divorced
- ❒ Never Married
- ❒ Single
- ❒ Separated
- ❒ Widowed

HABITS
- ❒ Exercise

BEVERLY HILLS DRx

Current Medical History

Family Medical History - Please check all that apply				
❒ Alcoholism	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Anemia	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Cancer	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Chronic Disabling Disease	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Diabetes Mellitus	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Gout	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Heart Disease	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ High Cholesterol	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ HIV / AIDS	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Hypertension	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Kidney Disease	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Liver Disease	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Osteoarthritis	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Osteoporosis	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Rheumatoid Arthriti	❒ Father	❒ Mother	❒ Brother	❒ Sister
❒ Other:	❒ Father	❒ Mother	❒ Brother	❒ Sister

Medications

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list:____

____

Are you taking, or have you taken any blood thinners? ❑ Yes ❑ No If yes, please list:________________________________

Medication / Vitamins	Dosage	Frequency

PLEASE SIGN: The information on these forms are accurate to the best of my knowledge.

Signature ______________________________ Date ______________________________

FOR OFFICE USE ONLY

Reviewed by ____________________MD / Nurse Date:__________________ Reviewed by____________________ MD / Nurse Date:__________________

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