Ethos Regenerative Medical Group New Patient Information

Who can we thank for referring you to our office? ___________________________ Date: _____

First Name: ____________________________ Last Name: ______________________________

Date of Birth: ___ / ___/ __ ☐ Male ☐ Female ☐ Single ☐ Married

Name of Spouse/significant other: ________________________ Number of children: ________

Address: _______________________________City: ____________________State: ____ Zip: _______
Phone: Cell: _________________Work:__________________ SSN: ____________________
E-Mail Address: ____

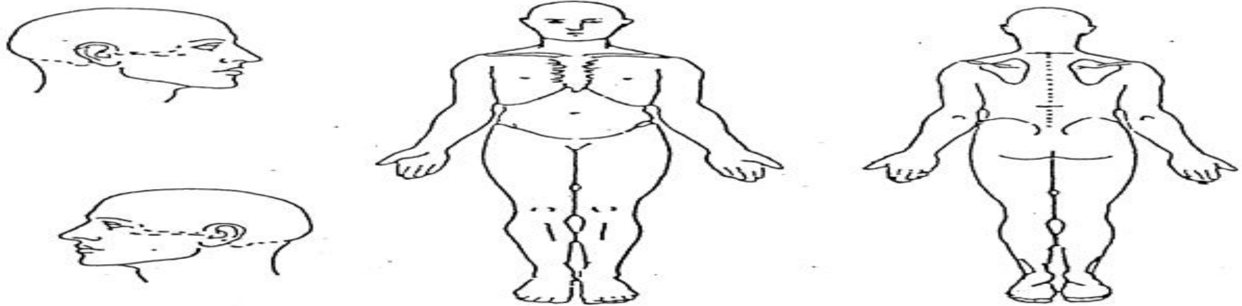
Preferred Method of Contact for appointments: Phone Call ____ Text ____ Email ____

What condition or symptoms are you wanting the Doctors help with? (List in order of importance to you)

1) ____ When did issue begin? ____________
2) ____ When did issue begin? ____________
3) ____ When did issue begin? ____________

What do you believe Caused your current health problem?
____

Please mark (X) on the picture where you have any discomfort, pain or other symptoms;



Please check ALL which suffer or are more difficult as a result of your health complaints:

☐ Sports	☐ Family Time	☐ Cleaning	☐ Exercise	☐ Work
☐ Sleep	☐ Hobbies	☐ Cooking	☐ Bathing	☐ Other

Have you ever had any imaging for this complaint? (MRI, CT, X-rays):____Date:_______

What treatments have you undergone in the past that has not fixed your complaints?

☐ Medications	☐Physical Therapy	☐ Injections	☐ Massage	☐ Chiropractic
☐ Acupuncture	☐Personal Training	☐ Homeopathy	☐ Herbs	☐ Exercise

Other: ____

Have you been to a Chiropractor in the past for this complaint or prior complaints? ☐ Yes ☐ No
If yes: Date of your last Adjustment: ___________ How long were you treated? __________________

Do you have a history of Spine, Disc or Nervous System problems: ❑ Yes ❑ No If yes, explain:
____

Quality of Life in the following areas: 1 - 10 Scale (10 being the best)

1. Sleep ___ 2. Digestion: ___ 3. Focus/ Productivity: ____ 4. Energy: ___ 5. Immune System: ___

6. Reproductive Health: ____ 7. Metabolism/ Weight: ____ 8. Hormones: ___

Do you smoke: ☐ Yes ☐ No For how many years: ____

Do you Sit at work: ☐ Yes ☐ No Number of hours: ____ For how many years: ____

List ALL over the counter, medications, herbs, nutritional supplements you take, use back if necessary:

Medication/ Supplements	Dose and Frequency	Reason for Taking (for what symptoms)	Start Date	Prescribed By:

Do you have a Primary Care Physician? ☐ Yes ☐ No Clinic Name: _________________________________
Physician Name: __________________________________ Phone Number: ______________________________

Privacy Authorization:

Our goal is to make your experience with us exceptional. Your signature below will verify that you have been given the option to review and understand our notice of privacy practices. You agree that we may contact you via email, phone, or mail regarding your care and to keep you up to date on events taking place within the office. We will not share your information, we use Audio, video, and photos at functions, during training, in office, we use these in research studies, testimonials, and social media.

Assignment of Insurance Benefits:

We will verify your insurance before your report of findings with Dr. Black, and we will discuss any insurance coverage & expected contributions towards our recommendations for you. We will file directly to your insurance company for your care. All fees for today's exam, scans, and any x-rays will be due in full today, these fees will be discussed with you prior to services being performed today. The undersigned patient and or responsible party, in addition to continuing personal responsibility and consideration of treatment rendered, assigns to Ethos Regen, PLLC & Associates the following rights:

Release Information:

You are authorized to release information concerning my condition and treatment to my insurance company, or insurance adjuster, for purposes of processing/appealing my claim for benefits and payment of services.

All payments for services will be made payable to: Ethos Regenerative Medical Group, PLLC

I hereby grant Ethos Regenerative Medical Group, PLLC the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance group, company representing payment for treatment, consultations and any and all health care rendered.

Print Name: _____________________ Signed: __________________________ Date: ____ / ____/____