

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: _____

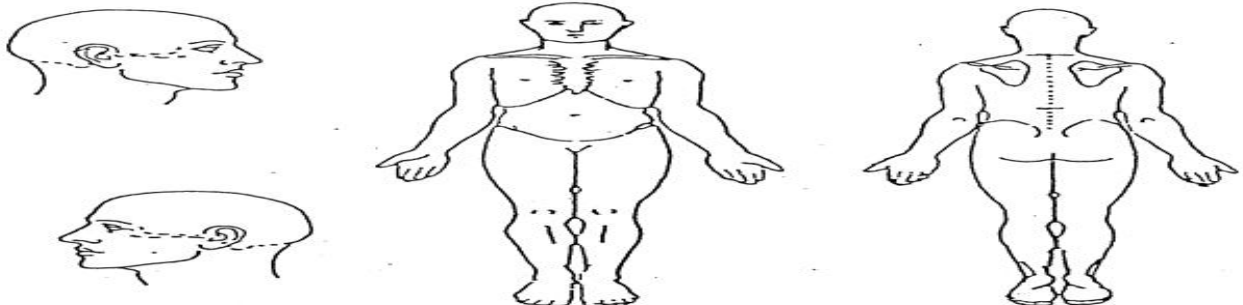
Preferred Method of Contact for appointments: Phone Call _____ Text _____ Email _____

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:

<input type="checkbox"/> Sports	<input type="checkbox"/> Family Time	<input type="checkbox"/> Cleaning	<input type="checkbox"/> Exercise	<input type="checkbox"/> Work
<input type="checkbox"/> Sleep	<input type="checkbox"/> Hobbies	<input type="checkbox"/> Cooking	<input type="checkbox"/> Bathing	<input type="checkbox"/> 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?

<input type="checkbox"/> Medications	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Injections	<input type="checkbox"/> Massage	<input type="checkbox"/> Chiropractic
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Personal Training	<input type="checkbox"/> Homeopathy	<input type="checkbox"/> Herbs	<input type="checkbox"/> 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:

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

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: ____

FEMALES: Are you Pregnant: Y/ N Date of Last Menstrual Cycle: ___/___/____. (Initial)_____

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: ___/___/____