PATIENT INFORMATION

Patient Name: ____ **Date of Birth:** __________________

Gender: □ Male □ Female **S.S. #** ***(for VA patients ONLY)*****:** ____

Street Address: ____

City: ____ **State:** ________ **Zip:** ________________

Cell Phone #: ________________________________ **Home Phone #:** _______________________________

Email: ____

How did you hear about our office? ____

EMERGENCY CONTACT

Emergency Contact Name: ____

Phone #: ____________________________________ **Relationship:** ____________________________

PRIMARY CARE PROVIDER INFORMATION

Primary Care Physician: ___________________________________**Phone:** ______________________________

Do we have your permission to contact your physician regarding your care in our office? ☐No ☐ Yes

OFFICE POLICY

__________ *(Initial)* Please be on time for your scheduled appointment(s). Being late or last-minute cancellations will cause scheduling disruptions, which interfere with the quality of care you and other patients receive. If you are unable to keep your **Examination**, **BioTE** or **Functional Medicine/Primary Care** appointment time, we require 24-hour notice. The fee for cancelled or no-show appointments is **$75**.

__________ *(Initial)* We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, Amex and CareCredit. Your timely payment allows us to provide services. For convenience, our office will collect at the time services are rendered or charge your credit card on file, unless other arrangements are made.

__________ *(Initial)* Revived Mobility LLC (DBA: Hybrid Health Center) provides services that may not be covered by insurance plans. We will verify individual insurance benefits; however, the patient is always responsible for payment of their care. Please understand that your insurance contract is between you and your insurance company. If there are any problems between you and your insurance company, you may file a grievance directly with your insurance company.

__________ *(Initial)* **ASSIGNMENT OF BENEFITS (AOB):** Your signature below assigns assignment to this office for the collection of benefits and authorizes Revived Mobility LLC (DBA: Hybrid Health Center) to release daily chart notes or any information deemed appropriate and necessary for the processing if claims for reimbursement of charges incurred (medical supplies, services, and/or medications). I authorize Revived Mobility LLC (DBA: Hybrid Health Center) to contact me by telephone or mail regarding medical supplies and/or medication(s) ordered.

Your signature authorizes that you understand the above office policy, assignment of benefits and agreement to pay all amounts that are not covered by your insurer(s), including applicable co-payments and/or deductibles, for which you are responsible for.

Patient Signature: ____ **Date:** _______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or healthcare operations.

____ ______________________________
Signature of Patient or Legal Representative **Date**

____ ______________________________
Printed Name of Patient **Legal Relationship to the Patient** *(if required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name: ______________________ Relationship: ______________ Phone: ________________
2. Name: ______________________ Relationship: ______________ Phone: ________________

Consent to email or text for appointment reminders and other healthcare communications.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messaging for appointment reminders and general health information is:

____________________________________. Please initial ________.

The email address that I authorize to receive email messages for appointment reminders and general health information is:

____________________________________. Please initial ________.

OR

____ I decline to receive communications via **text**.

____ I decline to receive communications via **email**.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I herby revoke my request to receive future appointment reminders or healthcare updates via text.

_____ I herby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient Signature: ______________________________________ Date: ______________

Reminder – Keep information to the minimum necessary and encrypt emails and texts whenever possible

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advise and covers only federal, not state law.

Patient Name: ______________________________ **Date of Birth:** _________________

MEDICAL HISTORY

ALLERGIES:

Name (latex, medications, food, etc.):	Reaction & Symptom:
Latex	
Iodine	
Lidocaine	

MEDICATION & VITAMINS:

Name:	Dosage (amount/daily):
Medication List Attached	

PAST MEDICAL & FAMILY HISTORY: For the conditions listed, check YES or NO if **you** or **anyone in your family (*father, mother, or siblings*)** has been affected, then write the relationship of the relative with the condition/disease on the adjacent space.

YES	NO	Condition	Relationship
		Alcoholism	
		Arthritis	
		Asthma	
		Auto Immune Disease	
		Bleeding Disorders	
		Blood Clot	
		Cancer & Type:	
		Circulation Problems	
		Chronic Pain	
		Depression / Anxiety	
		Diabetes – Type 1 or Type 2	
		Glaucoma / Eye Disease	
		Heart Disease	
		Hemochromatosis	
		High Blood Pressure	
		High Cholesterol	

YES	NO	Condition	Relationship
		HIV or any type of Hepatitis	
		Irregular Heartbeat	
		Kidney Disease	
		Liver Disease	
		Low Blood Pressure	
		Lung Disease *(not asthma)*	
		Mechanical Injury	
		Mental Illness	
		Migraines	
		Osteoporosis	
		Psychiatric Disorder	
		Seizures/Epilepsy	
		Sleep Apnea	
		Skin Disorders	
		Stroke and/or Heart Attack	
		Thyroid Disease	

Date of Last Physical: ______________________ □ Normal □ Abnormal

SURGICAL HISTORY:

Operation Type	Date
Bowel:	
Appendix Removal	
Gallbladder Removal	
Lung:	

Operation Type	Date
Heart:	
Orthopedic:	
Eye:	
Other:	

Please list all additional medical providers & approximate date of last visit:

Family / Primary Care: ______________________________

Orthopedic (bones & joints): ______________________________

Physical Therapy: ______________________________

Other Specialists *(Acupuncture, Chiroprator, Cardiologist, OBGYN, etc)*: ______________________________

____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Employment Status: ☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Other: ______________

Occupation: ______________________ **Employer:** ______________________

WHICH SUBTANCES DO YOU CONSUME:

Cigarettes:	☐ No ☐ Yes - amount per day:
Former Smoker:	☐ No ☐ Yes - Age started: Age quit:
eCigs or Vaporizers:	☐ No ☐ Yes
Tobacco/Dip/Chew:	☐ No ☐ Yes - how often:
Alcohol:	☐ No ☐ Yes - Amont/how often:
Caffeine:	☐ No ☐ Yes - Amount/how often:

EXERCISE:

Type:	☐ Aerobic	☐ Weights	☐ Walking	☐ Swimming	☐ Bicycling	☐ Running	☐ Other:
Frequency:	☐ none	☐ 1/week	☐ 2/week	☐ 3/week	☐ 4/week	☐ 5/week	

CARDIO-METABOLIC ASSESSMENT TEST (CMAT)

Do you have the following (if you answer YES to the following, skip the SYMPTOMS section):

YES	NO	Condition	YES	NO	Condition
		Undergoing external defibrillation			Absence of 2 or more limbs
		Implant pacemaker or cardiac devise or insulin pump			Arterial catheters on arm or leg or an arteriovenous (AV) fistula or shunt
		Dermatologic lesions or calluses (bottom of feet) in contact with electrodes			Bilateral mastectomy

SYMPTOMS Please check the symptoms you have experience **within the last 6-months *or* today**:

6 Months	Today	Symptom	6 Months	Today	Symptom
		Headaches			Bowel or bladder problems
		Fatigue			Skin, hair or nail changes
		Chest Pain			Burning sensations
		Shortness of breath			Digestive problems
		Heat intolerance			Pain
		Exercise intolerance			Lightheadedness
		Fainting or passing out			Dizziness
		Muscle weakness or paralysis			Numbness and tingling
		lack of concentration			Rapid heart beat

Patient Signature: ______________________________ **Date:** ______________

Patient Name: ____ Date: __________________________

MEDICAL CONDITION HISTORY –FEMALE ONLY

PERRINENT MEDICAL / SURGICAL HISTORY:

☐ Acne	☐ Breast Cancer	☐ Breast pain
☐ Endometriosis	☐ Epilepsy or seizures	☐ Excess Facial/body Hair
☐ Fibrocystic breasts	☐ Hair Thinning / Hair Loss	☐ Heavy periods
☐ Hysterectomy with removal of ovaries	☐ Hysterectomy (partial - uterus only)	☐ Infertility
☐ Irregular periods	☐ Ophorectomy (removal of ovaries only)	☐ Ovarian Cancer
☐ PCOS (Polycystic Ovarian Syndrome)	☐ Uterine Cancer	☐ Uterine Fibroids

GYNECOLOGIC HISTORY:

Date of last mammogram:	☐ Normal ☐ Abnormal	
Date of last pap smear:	☐ Normal ☐ Abnormal	**Have you ever had an abnormal pap?** ☐ No ☐ Yes
Date of last bone density:	☐ Normal ☐ Abnormal	
Date of last colonoscopy:	☐ Normal ☐ Abnormal	
Are you sexually active?	☐ No ☐ Yes	
Are you currently using birth control?	☐ No ☐ Yes: **what type:**	**Are you satisfied with it:** ☐ No ☐ Yes
Have you completed your family?	☐ No ☐ Yes	
Have you ever been treated for an STD?	☐ No ☐ Yes: **what type:**	
Are you currently on Hormone Replacement Therapy (HRT)?	☐ No ☐ Yes: **what type:**	
List any past HRT:		

MENSTRAL CYCLE HISTORY:

Age of first cycle:
Date of last cycle:
Number of days in between periods:
Length of periods (number of days bleeding):
Any recent changes in periods:

PREGNANCY HISTORY:

Total times pregnant:	**# of vaginal deliveries:**	**# of miscarriages:**
# of c-sections:	**# of tubal pregnancies:**	**# of abortions:**
Describe any pregnancy problems:		

Patient Signature: ____ **Date:** ________________

FEMALE HEALTH ASSESSMENT

Patient Name: ____ Date: __________________________

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

SYMPTOMS	NONE (0)	MILD (1)	MODERATE (2)	SEVERE (3)	VERY SEVERE (4)
Physical Exhaustion (fatigue, lack of memory, energy, stamina or motivation					
Sleep problems (difficulty falling asleep or sleeping through the night)					
Irritability (mood swings, feeling aggressive, anger easily)					
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)					
Decline in drive or interest (loss of "zest for life," feeling down or sad)					
Joint and muscular symptoms (poor recovery after workout, inability to add muscle, joint pain, muscle weakness)					
Difficulties with memory (concentration, finding the right word, or retaining information)					
Vaginal dryness or difficulty with sexual intercourse					
Sexual problems (change in desire, activity, orgasm and/or satisfaction)					
Sweating (night sweats or increased episodes of sweating)					
Hot flashes (burst that starts in the chest and lasts for short duration)					
Hair loss, thinning or change in texture of hair					
Feeling cold all the time, having cold hands and feet					
Headaches or migraines (increase in frequency or intensity)					
Weight (difficulty losing weight despite diet/exercise)					
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)					

TOTAL SCORE: _____________