## 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***

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 |
|---|---|---|
| | | Undergoing external defibrillation |
| | | Implant pacemaker or cardiac devise or insulin pump |
| | | Dermatologic lesions or calluses (bottom of feet) in contact with electrodes |
| | | Absence of 2 or more limbs |
| | | Arterial catheters on arm or leg or an arteriovenous (AV) fistula or shunt |
| | | Bilateral mastectomy |

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

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

**Patient Signature:** ______________________ **Date:** ______________

Patient Name: ____________________________________________ Date: _________________________

# MEDICAL CONDITION HISTORY – MALE ONLY

**PERRINENT MEDICAL / SURGICAL HISTORY:**

| | | |
|---|---|---|
| ☐ Elevated PSA | ☐ Erectile dysfunction | ☐ Frequent blood donations |
| ☐ History of anemia | ☐ Medication for high cholesterol | ☐ Non-cancerous testicular surgery |
| ☐ Non-cancerous prostate surgery | ☐ Prostate enlargement | ☐ Severe snoring |
| ☐ Testicular or prostate cancer | ☐ Trouble passing urine | ☐ Vasectomy |

| | |
|---|---|
| **Date of last prostate exam:** | ☐ Normal ☐ Abnormal |
| **Date of last colonoscopy:** | ☐ Normal ☐ Abnormal |
| **Are you sexually active?** | ☐ No ☐ Yes |
| **Are you using birth control?** | ☐ No ☐ Yes: **what type:** ☐ Vasectomy ☐ Condoms ☐ Depends on partner's contraception ☐ Other: |
| **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 part HRT:** | ☐ No ☐ Yes: **what type:** |

**Patient Signature:** ____________________________________________ **Date:** ___________________

# MALE 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) | | | | | |
| Sexual desire or performance (reduced or diminished) | | | | | |
| Erectile changes (weaker erections, loss of morning erections) | | | | | |
| Ejaculations (infrequent or absent) | | | | | |
| Sweating (night sweats or increased episodes of sweating) | | | | | |
| Hair loss, rapid or thinning | | | | | |
| 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: ____________