ANTI-AGING &
WELLNESS CENTER

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Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient information

Name: _____ Social Security Number _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Sex: ☐M ☐F Age: _____ Birth Date: _____ Marital Status:
Patient Employed by: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Whom may we thank for referring you? _____
Emergency contact person: _____
Emergency contact home #: _____ Emergency contact work #: _____

Primary insurance

Person responsible for account: _____
Relation to Patient: _____ Birth Date: _____ Social Security Number _____
Street address (if different from patient): _____
City: _____ State: _____ Zip: _____ Phone: _____
Person Responsible Employed by: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____ Phone: _____
Contract #: _____ Group #: _____ Subscriber #: _____
Name of the other dependents under this plan: _____

Additional insurance

Is the patient covered by additional insurance? ☐Yes ☐No (If Yes, enter details)
Subscriber Name: _____
Relation to Patient: _____ Birth Date: _____ Social Security Number _____
Street address (if different from patient): _____
City: _____ State: _____ Zip: _____ Phone: _____
Person Responsible Employed by: _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insurance Company: _____ Phone: _____
Contract #: _____ Group #: _____ Subscriber #: _____
Name of the other dependents under this plan: _____

Family medical history

	Age	Good Health	Poor Health	Deceased
Father				
Mother				
Brother(s)				
Sister(s)				
Grandparent(s)				

Medical history

Date of last visit: _____ Have you had any serious illnesses or operations? ☐Y ☐N

If yes, describe: _____

Are you currently under physician care? ☐Y ☐N If yes, describe: _____

Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate dates: _____

Have you ever taken diet pills? ☐Y ☐N If yes, give approximate dates: _____

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N

Check Y for yes or N for no if you have had any of the following:

☐Y ☐N AIDS/HIV positive	☐Y ☐N Cortisone treatment	☐Y ☐N Hepatitis	☐Y ☐N Seizures
☐Y ☐N Alcohol/drug abuse	☐Y ☐N Cough, persistent	☐Y ☐N High blood-pressure	☐Y ☐N Shingles
☐Y ☐N Anaphylaxis	☐Y ☐N Cough up blood	☐Y ☐N Jaw pain	☐Y ☐N Shortness of breath
☐Y ☐N Anemia	☐Y ☐N Diabetes	☐Y ☐N Kidney disease / malfunction	☐Y ☐N Skin rash
☐Y ☐N Arthritis, rheumatism	☐Y ☐N Epilepsy	☐Y ☐N Liver disease	☐Y ☐N Spina bifida
☐Y ☐N Artificial heart valves	☐Y ☐N Painting	☐Y ☐N Material allergies (latex, wool, metal, chemicals)	☐Y ☐N Stomach/intestinal problems
☐Y ☐N Artificial joints	☐Y ☐N Food allergies	☐Y ☐N Mitral valve prolapse	☐Y ☐N Stroke
☐Y ☐N Asthma	☐Y ☐N Glaucoma	☐Y ☐N Mother used recreational drugs, alcohol or smoked during pregnancy	☐Y ☐N Surgical implant
☐Y ☐N Atopic (allergy prone)	☐Y ☐N Headaches	☐Y ☐N Nervous problems	☐Y ☐N Swelling of the or ankles
☐Y ☐N Back problems	☐Y ☐N Heart murmur	☐Y ☐N Pacemaker/heart surgery	☐Y ☐N Thyroid disease or malfunction
☐Y ☐N Blood disease	☐Y ☐N Heart problems	☐Y ☐N Psychiatric care	☐Y ☐N Tobacco habit
☐Y ☐N Cancer	Describe: _____	☐Y ☐N Rapid weight gain or loss	☐Y ☐N Tonsillitis
☐Y ☐N Chemical dependency		☐Y ☐N Radiation treatment	☐Y ☐N Tuberculosis
☐Y ☐N Cholesterol problems	☐Y ☐N Hemophilia/ Abnormal bleeding	☐Y ☐N Respiratory disease	☐Y ☐N Ulcer/Colitis
☐Y ☐N Chemotherapy	☐Y ☐N Hereditary problems	☐Y ☐N Rheumatic/scarlet fever	☐Y ☐N Venereal disease
☐Y ☐N Circulatory problems	☐Y ☐N Herpes		

List any medications you are currently taking, if any:

_____

List any drug allergies, if any:

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I authorize the use of the signature on all insurance submissions.

Signature: _____ Date: _____

Payment is due in full at time of treatment unless prior arrangements have been approved.