THE RENEWAL POINT
Integrative Medical Center of Dan Watts, MD

GENERAL INFORMATION

Full Legal Name _____ E-Mail _____

Date of Birth _____ SS# _____

Address _____

_____

City _____ State _____ Zip _____

Home _____ Cell _____

Work _____ Fax _____

Occupation _____ Employer _____

SPOUSE/PARTNER INFORMATION

Spouse/Partner _____

Employer _____ Date of Birth _____

FAMILY MEDICAL HISTORY: *Has anyone in your family had any of the following? Please specify relationship.*

☐ Diabetes _____ ☐ Heart Disease _____ ☐ TB _____

☐ Breast Cancer _____ ☐ Colon Cancer _____ ☐ Cancer _____

☐ Osteoporosis _____ ☐ High Blood Pressure _____ ☐ Other _____

PERSONAL MEDICAL HISTORY: *Do you or have you ever had any of the following?*

☐ Heart Disease	☐ Kidney Infection	☐ Thyroid Disorders
☐ High Blood Pressure	☐ Bladder Infection	☐ Blood Disease
☐ Cancer	☐ Headaches	☐ Rheumatic Fever
☐ Breast Cancer	☐ Depression	☐ Liver Disease
☐ Anemia	☐ Hysterectomy	☐ Neurological Disorders
☐ Diabetes	☐ Genital Warts	☐ Altered Mood Changes
☐ Abnormal Pap	☐ Chlamydia	☐ Skin Disorders
☐ Osteoporosis	☐ Sexually Transmitted Diseases	☐ Herpes

Date of last Pap Smear _____ **Date of last Mammogram** _____

MEDICATION ALLERGIES:

_____

_____

SURGICAL HISTORY: *Please list any surgical procedures and the year*

_____

Integrative Medicine:

Dr. Watts and The Renewal Point Staff are expertly trained in Integrative Medicine. This form of practice uses the best of both Natural Preventative Medicine and Traditional Medical approaches to develop the best strategy for your long-term health. Many natural options to further your health may be discussed or recommended such as: vitamins, herbs and natural hormones. While usually considered a safer approach than pharmaceutical companies, they are not regulated by the FDA and are not covered by most traditional insurance companies.

5 Helpful Hints for Filing a Self-Filed Insurance Claim:

-Check with your insurance for out-of-network benefits. Our office became out-of-network effective 08/01/08
-You must know your benefits covering diagnostic testing and lab work ordered by an out-of-network doctor
-Obtain a claim form for a member filed claim from your insurance. This may be available online.
-Obtain the address to send your member filed claim form.
-Benefits will be paid directly to you.

Only as permitted or required by federal or state law, we may use your protected healthcare information to do the following: *To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol treatment/abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.*

_____

Signature *Date*

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Men and Women's Wellness Checklist

Patient Name: _____ Date: _____

Are you experiencing any of the following symptoms? (Hormones)

Women:

__ Hot flashes
__ Sleep disturbances
__ Night sweats
__ Mood Changes
__ Unexplained vaginal bleeding
__ Vaginal dryness
__ Painful intercourse
__ Decreased libido (desire for sex)
__ Urinary incontinence with coughing/sneezing

Men:

__ Decreased mental sharpness
__ Weight gain (mid-abdomen)
__ Urine frequency/urgency
__ Decreased stamina
__ Decreased muscle
__ Decreased libido (desire for sex)
__ "Blahs"
__ Erection difficulty

Are you experiencing any of the following symptoms? (Human Growth Hormone)

__ Memory
__ Reduced lean body mass
__ Reduced energy
__ Lack of positive well-being
__ Increased body fat
__ Decreased strength
__ Increased waist-to-hip ratio
__ Reduced Bone Mineral Density
__ Unexplained depression

Are you experiencing any of the following symptoms? (Gastrointestinal)

__ Gas, bloating, constipation
__ Allergies
__ Heartburn, GERD
__ Chronic yeast problems, Candida

Are you experiencing any of the following symptoms? (Adrenal/Thyroid)

__ Fatigue
__ Hair thinning/loss
__ Dizzy, light-headed
__ Weight gain
__ Low body temperature
__ Fibromyalgia, body aches
__ Brain fog
__ Endurance

Do you have any concerns about exposure to environmental toxins, pesticides, herbicides, occupational toxicity, city and farming pollution, or silver fillings in teeth? (Toxins) __ Yes __ No

__ Heart Disease
__ M.S.
__ Weakness
__ Memory
__ Tremors
__ Numbness
__ Cancer
__ Parkinson's

Are you experiencing any of the following symptoms? (Neurotransmitters)

__ Depression
__ Anxiety
__ Difficulty sleeping/sleep disturbance
__ Decreased interest in daily activities
__ Decreased ability to focus
__ Memory loss, mental sharpness

Do you have any concerns with your skin? (Skin)

__ Acne/scarring
__ Dry/oily skin
__ Fine lines/wrinkles
__ Other
__ Skin texture

Any specific areas of concern regarding weight management? (Body Composition)

__ Weight problem
__ Bulges, tummies, thighs, etc.
__ Overweight
__ Cellulite
__ Underweight
__ Sugar/carb cravings

Do you have a family history of? (Genetics)

__ Cancer
__ Arthritis/Rheumatoid/Lupus
__ Alzheimer's
__ Heart disease

Would you like improvements in any of the following areas?

__ Physical conditioning
__ Cardiovascular health
__ Low back pain
__ Other
___ Strength
___ Balance
___ Hip pain
___ Shoulder pain
___ Endurance
___ Neck pain
___ Knee pain
___ Overall fitness

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Patient Name: _____ Date: _____

Medication/Strength	Dosage

Supplement/Strength	Dosage

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The Renewal Point
HIPAA Compliance Notification

The misuse of protected health information has been identified as a national problem causing some patients inconvenience, aggravation, and money. We want you to know that all of the employees of The Renewal Point periodically receive training to assist them in understanding and complying with government rules and regulations regarding the Health Insurance Portability and Accountability Act ("HIPAA") with a particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. Other entities may have indirect treatment relationships with you (such as a physician interpreting a test or x-ray) and we may have to disclose personal health information for purposes of treatment or payment. These entities are most often not required to obtain patient consent.

You may refuse, in writing, the consent to the use or disclosure of your personal health information. Under this law, we then have the right to refuse to treat you should you refuse to disclose your personal health information. At any time in the future, you may request to refuse all or part of disclosure to your personal health information. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

It is our policy to determine appropriate uses of personal health information in accordance with the governmental rules, laws, and regulations. We want to ensure that The Renewal Point never contributes in any way to the growing problem of improper disclosure of personal health information.

We also know that we are not perfect. Because of this fact, our policy is to listen to our patient and employees without any thought of penalty if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

If you have any questions, please ask to speak with our Privacy Officer. If you would like a copy of the complete Notice of Privacy Practices, please ask the receptionist.

I acknowledge I have received a copy of the Notice of Privacy Practices for The Renewal Point.

_____ _____

Signature of Patient Date

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In an effort to maintain the highest standards of confidentiality with our patients, we ask that you review the following and answer where indicated. Thank you.

PATIENT COMMUNICATION CONSENT

Patient Name: _____
Please Print (Last Name) (First Name) (M.I.)

Do we have your permission to do the following?

- Mail the following information to your address on file:
  An appointment reminder card/packet? Y____ N____

  Test results? Y____ N____

- Leave the following information on your home/cell answering machine/voicemail:
  Appointment information? Y____ N____

  Billing information? Y____ N____

  Medical Information? Y____ N____

- Leave the following information on your work answering machine/voicemail:
  Appointment Information? Y____ N____

  Billing Information? Y____ N____

  Medical Information? Y____ N____

- Send you a reminder text message regarding upcoming appointments? Y____ N____

I give my permission to share appointment information with the person listed below:

_____ Relationship: _____

_____ Relationship: _____

I give my permission to share medical information including biopsy and lab results with the person listed below:

_____ Relationship: _____

_____ Relationship: _____

I give my permission to share billing information with the person listed below:

_____ Relationship: _____

_____ Relationship: _____

Patient Signature: _____ Date: _____

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New Patient Survey

Thank you for taking the time to answer a few questions that will help us spread the word about our programs and services.

1. Please indicate other Renewal Point programs you are interested in:
   - ☐ Age Management
   - ☐ Men's Health
   - ☐ Hormone Balancing
   - ☐ Well Woman
   - ☐ Gynecology
   - ☐ Weight Loss
   - ☐ Brain Health
   - ☐ IV Therapy
   - ☐ Thermography
   - ☐ Nutritionals
   - ☐ CKC Strength & Conditioning
   - ☐ Hormone Injectables (Growth Hormone, Testosterone)
   - ☐ Other _____

2. How did you hear about us? Many of our patients tell us that they wish they had found The Renewal Point sooner. We want to make sure that we are doing a good job of reaching out to people who are in need of our services. If you could please check the way(s) that you found us, we would greatly appreciate it!
   - ☐ Seminar
   - ☐ Facebook
   - ☐ West Coast Woman
   - ☐ Internet/Google Search
   - ☐ Individual Referral (Friend, Physician, or Staff member)
   - ☐ I'm a former patient
   - ☐ Other _____

3. If referred by an individual, do we have your permission to thank those responsible for your enrollment in our program? (To express our gratitude to our friends that refer new patients to our practice, we send them a gift.)

   Yes_____ No_____ Who can we thank? _____
   Please only list one person (the most influential)

4. If you would like to receive educational articles, specials, and event announcements (approximately 2 emails per month), please print your email address here:

   _____

   (We only use this email address for purposes listed above; for our complete web-based Privacy Policy, you can visit our website: https://www.therenewalpoint.com/privacy-policy)

Your Name _____ Phone _____ Date: _____

Signature _____