

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.*

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> TB _____ |
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other _____ |

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Altered Mood Changes |
| <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> 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 _____

Men and Women's Wellness Checklist

Patient Name: _____ Date: _____

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

Women:

- | | |
|---|--|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Decreased libido (desire for sex) |
| <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Urinary incontinence with coughing/sneezing |
| <input type="checkbox"/> Unexplained vaginal bleeding | |

Men:

- | | |
|---|--|
| <input type="checkbox"/> Decreased mental sharpness | <input type="checkbox"/> Decreased muscle |
| <input type="checkbox"/> Weight gain (mid-abdomen) | <input type="checkbox"/> Decreased libido (desire for sex) |
| <input type="checkbox"/> Urine frequency/urgency | <input type="checkbox"/> "Blahs" |
| <input type="checkbox"/> Decreased stamina | <input type="checkbox"/> Erection difficulty |

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Memory | <input type="checkbox"/> Lack of positive well-being | <input type="checkbox"/> Increased waist-to-hip ratio |
| <input type="checkbox"/> Reduced lean body mass | <input type="checkbox"/> Increased body fat | <input type="checkbox"/> Reduced Bone Mineral Density |
| <input type="checkbox"/> Reduced energy | <input type="checkbox"/> Decreased strength | <input type="checkbox"/> Unexplained depression |

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

- | | |
|--|--|
| <input type="checkbox"/> Gas, bloating, constipation | <input type="checkbox"/> Heartburn, GERD |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic yeast problems, Candida |

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

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Brain fog |
| <input type="checkbox"/> Hair thinning/loss | <input type="checkbox"/> Low body temperature | <input type="checkbox"/> Endurance |
| <input type="checkbox"/> Dizzy, light-headed | <input type="checkbox"/> Fibromyalgia, body aches | |

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

- | | | |
|--|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Memory | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> M.S. | <input type="checkbox"/> Tremors | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness | |

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

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty sleeping/sleep disturbance | <input type="checkbox"/> Decreased ability to focus |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Decreased interest in daily activities | <input type="checkbox"/> Memory loss, mental sharpness |

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

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Acne/scarring | <input type="checkbox"/> Fine lines/wrinkles | <input type="checkbox"/> Skin texture |
| <input type="checkbox"/> Dry/oily skin | <input type="checkbox"/> Other | |

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

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Weight problem | <input type="checkbox"/> Overweight | <input type="checkbox"/> Underweight |
| <input type="checkbox"/> Bulges, tummies, thighs, etc. | <input type="checkbox"/> Cellulite | <input type="checkbox"/> Sugar/carb cravings |

Do you have a family history of? (Genetics)

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Arthritis/Rheumatoid/Lupus | | |

Would you like improvements in any of the following areas?

- | | | |
|--|--|--|
| <input type="checkbox"/> Physical conditioning | <input type="checkbox"/> Strength | <input type="checkbox"/> Endurance |
| <input type="checkbox"/> Cardiovascular health | <input type="checkbox"/> Balance | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Other | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Overall fitness |

**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

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: _____

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?

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 _____