MAUI REGENERATIVE MEDICINE

2310 Umi Place Haiku Hawaii 96708
Office: 808-575-2328
www.mauiregenerativemedicine.com

Patient History Information

Name: _____ Date: _____
Address: _____ State/Zipcode: _____

Phone Home Cell SSN#
Age Date of Birth Sex M F
Occupation Employer
Marital Status: S M W D No. of Children: Spouse Name

Emergency Contact Name and Phone: _____
Email: _____
How did you find out about our office? _____
How do you prefer we contact you: _____
What is the reason for this visit?_____

Is this condition due to: Auto accident Work Injury Other accident Illness Other

Are symptoms: Improving Getting worse About the same Intermittent
Date symptoms appeared: Have you ever had these symptoms before? Yes No
Have you seen any of the following doctors for this? MD Naturopathic Dr
Chiropractor Acupuncturist Other: _____
Therapy Received:_____Dates treated:_____
Diagnosis: _____
Reason for termination of treatment: _____
Medications Prescribed:_____
Doctors Name:_____

I understand that a 24 hour advance notification is required for scheduling or cancelling of appointments to avoid a charge. I understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patients Signature: Date

Please apply check to boxes below: C =currently P =previously N= never

GENERAL SYMPTOMS

C	P	N	
			HEADACHE
			FEVER
			CHILLS
			NIGHT SWEATS
			DIZZINESS
			CONVULSIONS
			LOSS OF SLEEP
			FATIGUE
			NERVOUSNESS
			Loss of Weight
			Numbness in extremeties
			Wheezing

MUSCLE & JOINTS

			Weakness
			Twitching
			Stiff Neck
			Bachache
			Swollen joints
			Tremors
			Painful Tailbone
			Foot trouble
			Hernia
			Pain in btwn Shoulders
			Spinal Curvature

SKIN/ALLERGIES

			Skin eruptions
			Itching
			Brusing Easily
			Dryness
			Boils
			Sensitive skin
			Hives
			Eczema
			Psoriasis

HABITS

			Smoking
			Alcohol
			Coffee

RESPIRATORY

			Chronic Cough
			Spitting Blood
			Spitting Phlegm
			Chest Pain
			Difficult breathing

GASTRO-INTESTINAL

			Poor Appetite
			Poor Digestion
			Excessive Hunger
			Belching/Gas
			Nausea
			Vomiting
			Vomiting blood
			Pain over stomach
			Constipation
			Diarrhea
			Colon trouble
			Hemorrhoid
			Liver toruble
			Jaundice
			Gall bladder trouble

CARDIO-VASCULAR

			Rapid heart
			Slow heart
			High Blood pressure
			Low Blood pressure
			Pace Maker
			Pain over heart
			Prev. Heart trouble
			Swelling ankles
			Poor circulation
			Varicose veins
			Strokes

EYE-EAR-NOSE-THROAT

C	P	N	
			Poor vision
			Crossed eyes
			Pain in eyes
			Deafness
			Earache
			Ear Noises
			Ear Discharge
			Nasal Obstruction
			Nose Bleeds
			Sore throat
			Hoarseness
			Hay Fever
			Asthma
			Frequent colds
			Enlarged thyroid
			Tonsillitis
			Sinus trouble

GENITO-URINARY

			Freq. urination
			Painful urination
			Blood in urine
			Kidney Infection
			Bedwetting
			Incontinence
			Prostrate trouble

WOMEN ONLY

			Painful periods
			Excessive flow
			Irregular cycles
			Hot Flashes
			Cramps or Backaches
			Miscarriage
			Vaginal Discharge
			Pregnant at this time
			Abnormal Pap

	Arthritis
	Epilepsy
	Mental Disorder
	Lumbago
	Eczema

Have you had any of the following:

	Appendicitis
	Pneumonia
	Rheumatic Fever
	Polio
	Tuberculosis
	Whooping Cough
	Anemia
	Measles
	Mumps

	Chicken Pox
	Diabetes
	Cancer
	Heart Disease
	Goiter
	Influenza
	Pleurisy
	Alcoholism
	Venereal Disease

Family History/List Member:

Diabetes

Heart

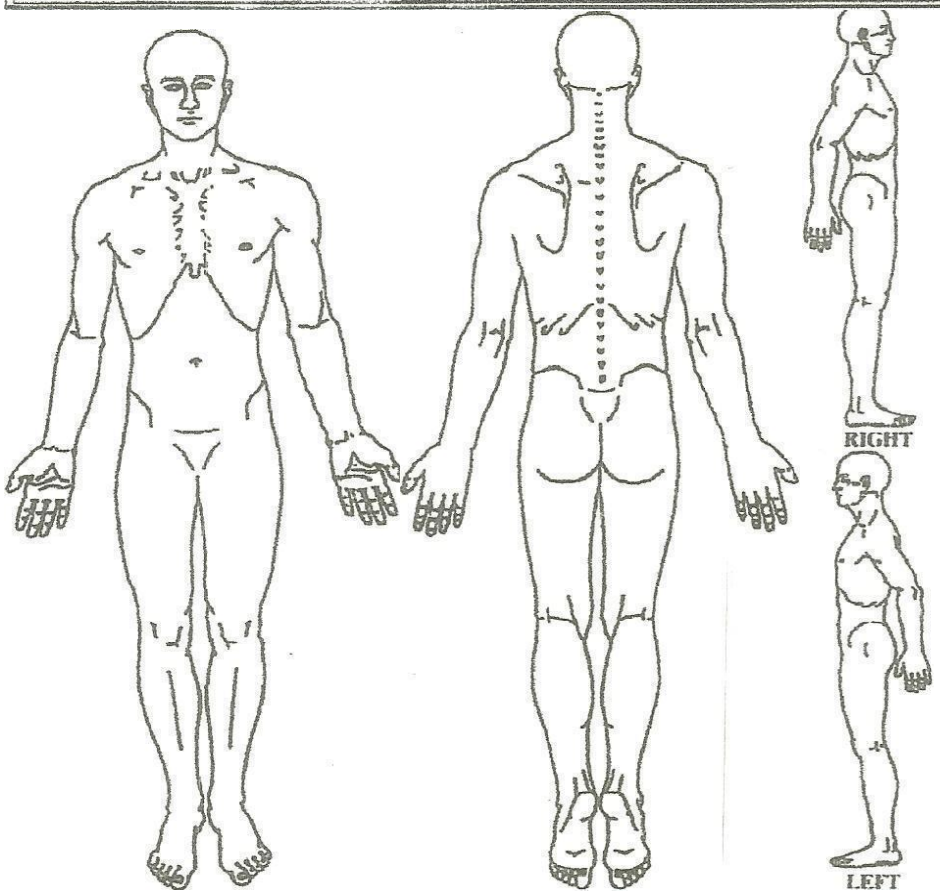
Kidney

Cancer

NAME (Please Print):_____ DATE:_____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

KEY:	S=STIFFNESS	B=BURNING	N=NUMBNESS
	P=SHARP PAIN	T=TINGLING	D-DULL PAIN



FINANCIAL POLICIES

Please take time to read and sign this financial responsibility statement before your first visit.

PAYMENT POLICY:

All account balances are due at the time of service. We reserve the right to not extend credit, as this is not a service we guarantee. We accept cash, checks, MasterCard, and Visa.

INSURANCE POLICY:

We do not accept insurance at this time. We do not offer billing services for insurance companies.

INTEREST FEES: There is no interest or finance charge on current accounts. After 60 days, all accounts are subject to a monthly finance charge of 2.0% of the unpaid balance, which is an annual percentage rate of 24% (or a minimum charge of $1.00).

MISSED / LATE CANCELLATION APPOINTMENT FEES:

We require 24 hours notice for rescheduling or canceling patient appointments.

We may charge for missed appointments, or appointments not canceled or rescheduled within the 24 hour time frame as stated above a fee of $100.00.

ACKNOWLEDGMENT:

I have read this financial policy statement and understand its terms. I understand that delinquent accounts may be assigned to a credit reporting collections service. If it becomes necessary to pursue collections of any amount owed, I agree to pay for all costs and expenses, including reasonable attorney fees. There will be a $50.00 fee added to any accounts referred to collections. I hereby authorize the Maui Regenerative Medicine to release any information necessary to secure payment.

Print Patient's Name:_____
D.O.B._____

Responsible Party Relationship to patient_____SSN# : _____

Signature of responsible party_____ _____Date_____