MAUI REGENERATIVE MEDICINE

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

Patient History and Information

Name: _____

Date: _____

Address: _____

State/Zipcode: _____

Phone Home: _____

Cell: _____

(Hormone PT only) DL#: _____

Age: _____

Date of Birth: _____

Sex: ____ M ____ F

No. of Children: _____

Occupation: _____

Employer: _____

Marital Status: ____ S ____ M ____ W ____ D

Email: _____

Emergency Contact Name and Phone: _____

How did you find out about our office? _____

Preferred contact method: _____

What is the reason for this visit? _____

Is this condition due to: ____ Auto Accident ____ Work Injury ____ Illness ____ Other _____

Are symptoms: ____ Improving ____ Getting Worse ____ About the same ____ Intermittent

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Date symptoms appeared: _____

Have you ever had these symptoms before? ____ Yes ____ No

Have you seen any other doctors for this? ____ Naturopathic Dr. ____ Chiropractor ____ Acupuncturist ____

MD ____ Other _____

Doctors Name: _____

Therapy Received: _____

Dates treated: _____

Diagnosis: _____

Reason for termination of treatment: _____

Medications Prescribed: _____

Current list of medications: _____

Known Allergies: _____

Imaging for This Condition? ____ X-ray ____ MRI ____ Ultrasound

Date of Imaging: _____

Patient Signature: _____

Date: _____

By signing above I understand that a 24 hour notice is required for scheduling or cancellation 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.