KMW | KEYSTONE MEDICAL WELLNESS

PATIENT INFORMATION

Today's Date:_________/____________/__________

Name:____**Date of Birth:**________/________/_____________

Marital Status: Single Married Divorced Widow **Sex:** Male Female **Social Security:** ________/_____/______

Address:____**City:**________________**State:**_______**Zip:** ______________

Phone:______-________-_________Work Cell Home **E-Mail:** ____

Emergency Contact:

Name:_______________________________________**Relationship:** ______________ **Phone:**_____-________-_________

Preferred Pharmacy:_______________________**Cross Roads:**____

INSURANCE INFORMATION

(used for bloodwork only)

Insurance Carrier:____________________________________ Insurance Phone: _________________________________

Member ID Number:____Group Number: ___________________________

Employer Name:___________________________________Address: ____

Insured Name and DOB:______________________________________Insured Social Security:________/____/__________

How did you hear about our office?

- ☐ Website
- ☐ Google
- ☐ Drive By or Walk-in
- ☐ Yelp
- ☐ Facebook / Instagram
- ☐ Referred by:_____________________

What services are you interested in?

- ☐ Hormone Replacement Therapy
- ☐ Medical Weight Loss
- ☐ Pain Management
- ☐ Stem Cell / Regenerative Medicine
- ☐ IV Infusion Therapy
- ☐ Peptide Therapy
- ☐ Other:__________________________

HIPAA – AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

I hereby authorize medical providers and personnel of Keystone Medical Wellness to discuss my protected health information with:

Name:____Relationship:____

Name:____Relationship:____

I understand that I have the right to revoke this authorization, in writing, at any time.

____

PATIENT PRINTED NAME PATIENT SIGNATURE DATE

KMW KEYSTONE MEDICAL WELLNESS

HEALTH HISTORY

Name: ____Date:_______/________/___________

Please list any current medical providers you are currently under the care of :

NAME/SPECIALITY	PHONE/LOCATION	TREATMENT

Please list any current treatments you are currently receiving:

1.	4.
2.	5.
3.	6.

Please mark if YOU or your Parents have/had any of the following:

	Self	Mother	Father		Self	Mother	Father
Heart Murmur (mitral valve prolapse)				HIV/AIDS Positive			
Anemia or any bleeding disorder				Stomach Ulcers			
Diabetes				Pacemaker			
Epilepsy or seizures				Psychosis			
Migraines				Cancer			
Fainting or dizziness				Enlarged lymph nodes			
Liver disease				Radiation therapy			
Shortness of breath or chest pain				Slow-healing mouth sores			
Hypertension (controlled/uncontrolled)				Venereal disease			
Thyroid disease (goiter)				Recurring Infections			
Heart attack or stroke				Glaucoma			
Kidney disease				Arthritis			

Please list all surgeries & their dates:

Tobacco Use? Never Former Current If so, how much/day? ______ Alcohol Use? Yes No If yes, how often? _________

WOMEN: *Are you pregnant or nursing?* Yes No *Chance of Pregnancy?* Yes No *On Birth Control?* Yes No

ALLERGIES? Please ALL food & drug allergies

Please list all current medications & dosages. Including RX, Vitamins, Supplements, and any Over the Counters.

1.	5.
2.	6.
3.	7.
4.	8.

HORMONE DEFICIENCY SYMPTOMS

(Circle best answer)

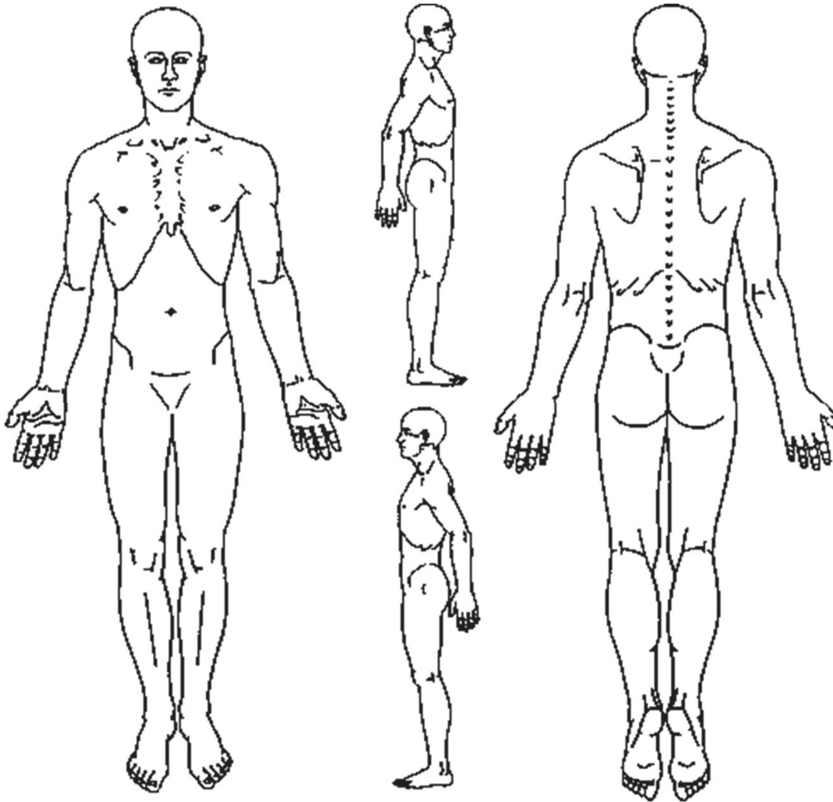
WOMEN				MEN			
Brain Fog	None	Sometimes	Often	Brain Fog	None	Sometimes	Often
Anxiety/Stress	None	Sometimes	Often	Anxiety/Stress	None	Sometimes	Often
Depression	None	Sometimes	Often	Depression	None	Sometimes	Often
Hot Flashes	None	Sometimes	Often	Decrease in Muscle Strength	None	Sometimes	Often
Sleeping Problems	None	Sometimes	Often	Sleeping Problems	None	Sometimes	Often
Fatigue	None	Sometimes	Often	Fatigue	None	Sometimes	Often
Irritability	None	Sometimes	Often	Irritability	None	Sometimes	Often
Loss of Libido	None	Sometimes	Often	Loss of Libido	None	Sometimes	Often
Weight Gain	None	Sometimes	Often	Weight Gain	None	Sometimes	Often
Vaginal Dryness	None	Sometimes	Often	Lack of Morning Erection	None	Sometimes	Often
Night Sweats	None	Sometimes	Often				

Review of Current Symptoms:

Fever		Leg Pain w/ walking		Muscle Cramping		Seizures	
Chills		Dry Cough		Joint Pain		Heat Intolerance	
Change of Appetite		Productive Cough		Joint Swelling		Cold Intolerance	
Somnolence		Shortness of breath		Rash		Excessive thirst	
Changes in Vision		Nausea or Vomiting		Mole changes		Excessive hunger	
Ear Pain		Diarrhea		Non-healing sores		Easy Bruising	
Ear Discharge		Constipation		Skin Itch		Hives	
Nasal Discharge		Abdominal pain		Hair Loss		Seasonal allergies	
Sinus Pressure		Burning on urination		Headache		Food allergies	
Sore Throat		Frequent Urination		Muscle weakness			
Hoarseness		Urgent Urination		Numbness/tingling			
Chest Pain		Blood in Urine		Memory Loss			
Chest Palpitations		Urine Incontinence		Dizziness			
Leg Swelling		Muscle Pain		Loss of balance			

PAIN MANAGEMENT

If you have pain, please circle the degree of pain you have (0 being no pain and 10 being excruciating pain), then list the quality of pain (aches, stabbing, numbness, etc.) as well as frequency (daily, weekly, intermittently, etc.)



Pain Identification Key

C = Cramping

A = Aches

P = Pins / Needles

B = Burning

S = Stabbing

N = Numbness

T = Throbbing

SH = Sharp

TE = Tender

O = Other

0 1 2 3 4 5 6 7 8 9 10

PATIENT PRINTED NAME PATIENT SIGNATURE DATE

3076 E Chandler Heights Rd. Ste 115 Gilbert, AZ 85298

Phone 480-499-4441 ♦ Fax: 480-499-5604 ♦ www.keystonemedicalwellness.com

KMW | KEYSTONE
MEDICAL WELLNESS

FINANCIAL POLICY

Your clear understanding of our practice financial policy is important to our professional relationship. We make every effort to keep our fees reasonable while at the same time covering the cost of the services we provide.
Payment of your bill is considered part of your overall treatment. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies:

Fees and Payments

Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with Cash, Visa, Mastercard, Discover, American Express, HSA & FSA Cards.

Family Medical Leave Act and Disability Paperwork

If your employer requires Family Medical Leave Act (FMLA) or Disability paperwork to be completed by your provider, we are happy to complete these forms for you; however, there is a 5-7 business day turnaround and a charge of $75.00, payable in advance.

Medical Records

In order to follow Arizona State law and HIPAA regulations, we charge a flat fee of $55.00 for records exceeding 15 pages. However, as always, if a collaborating physician (primary care or specialist) requests portions of your record to assist in your care, there is no charge.

Miscellaneous Charges

Lab Charges -– You may get a separate bill from the lab facility that performs your lab work. These charges should be discussed directly with the lab facility.

Cancellations -- If you are unable to keep a scheduled appointment, you must call at least one (1) business day in advance, or we may consider you a "no-show."

No-shows - As permitted by state law, you may be discharged as a patient following three (3) no-shows in a one-year period (365 days).

Card-On-File Process

You will be provided the option to save a credit card when you check-out for your visit. The information will be held securely until a request is submitted by you to remove, change, or update the card. The "Card-on-File" program simplifies payments for you and eases the administrative burden on your provider's office. If you have any questions about the card-on-file payment method, please let us know.

____

PATIENT PRINTED NAME   PATIENT SIGNATURE   DATE