KEYSTONE MEDICAL WELLNESS

PATIENT INFORMATION

Today's Date:_____/_____/_____

Name:_____ Date of Birth: _____/_____/_____

Address:_____City:_____State:_____Zip: _____

Phone:_____-_____-_____ E-Mail: _____

Emergency Contact:_____Relationship: _____ Phone:_____

Preferred Pharmacy:_____Crossroads: _____

How did you hear about Us?
(Please check all that apply)

- ☐ Website
- ☐ Google
- ☐ Drive By or Walk- In
- ☐ YELP
- ☐ Facebook / Instagram
- ☐ Referred By Person:

_____

Interested In: (Please check all that apply)

- ☐ Hormone Replacement
- ☐ Weight Loss
- ☐ Peptides
- ☐ Stem Cells
- ☐ Pain Management
- ☐ IV 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**

KEYSTONE MEDICAL WELLNESS

HEALTH HISTORY

Please list approximate date of your last:

Blood work_____EKG_____Physical_____Hospitalization _____

If test results were abnormal, please describe: _____

CURRENT MEDICAL PROVIDERS

Please list current Providers you are seeing and Treatments:

NAME/SPECIALITY	PHONE/LOCATION	TREATMENT

SURGICAL HISTORY

Please list all surgeries and their dates

WOMEN ONLY

Pregnant	YES	NO
Nursing	YES	NO
Any Chance of Pregnancy	YES	NO
Using Birth Control	YES	NO

FAMILY HISTORY

Please Check if you or your immediate family has been diagnosed with 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				Venereal disease			
Thyroid disease (goiter)				Recurring Infections			
Heart attack				Glaucoma			
Stroke				Arthritis			
Kidney disease							

SOCIAL HISTORY

Alcohol Use	YES	NO		How Often?
Tobacco / Smoking / Vaping	NEVER	FORMER	CURRENT	How Much/day?
Recreational Drug Use	NEVER	FORMER	CURRENT	How Often?

ALLERGIES

Please list all Drug & Food Allergies

MEDICATIONS

Please List ALL CURRENT medications (Prescription, Over the Counter & Vitamins) & Dosages

1.	5.
2	6.
3.	7.

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 SYMPTOMS (Check all that apply)

Fever		**Leg Swelling**		**Muscle Pain**		**Dizziness**	
Chills		**Leg Pain with Walking**		**Muscle Cramping**		**Loss of balance**	
Change in appetite		**Dry Cough**		**Joint Pain**		**Seizures**	
Somnolence		**Productive Cough**		**Joint Swelling**		**Heat Intolerance**	
Changes in Vision		**Shortness of Breath**		**Rash**		**Cold Intolerance**	
Eye Pain		**Nausea / Vomiting**		**Mole Changes**		**Excessive Thirst**	
Ear Pain		**Diarrhea**		**Non-Healing Sores**		**Excessive Hunger**	
Ear Discharge		**Constipation**		**Skin Itch**		**Lymph Node Enlargement**	
Nasal Discharge		**Abdominal Pain**		**Hair Loss**		**Easy Bleeding**	
Sinus Pressure		**Burning on Urination**		**Headache**		**Easy Bruising**	
Sore Throat		**Frequent Urination**		**Muscle Weakness**		**Hives**	
Hoarseness		**Urgent Urination**		**Numbness**		**Seasonal Allergies**	
Chest Pain		**Blood in Urine**		**Tingling**		**Food Allergies**	
Chest Palpitations		**Urine Incontinence**		**Memory Loss**			

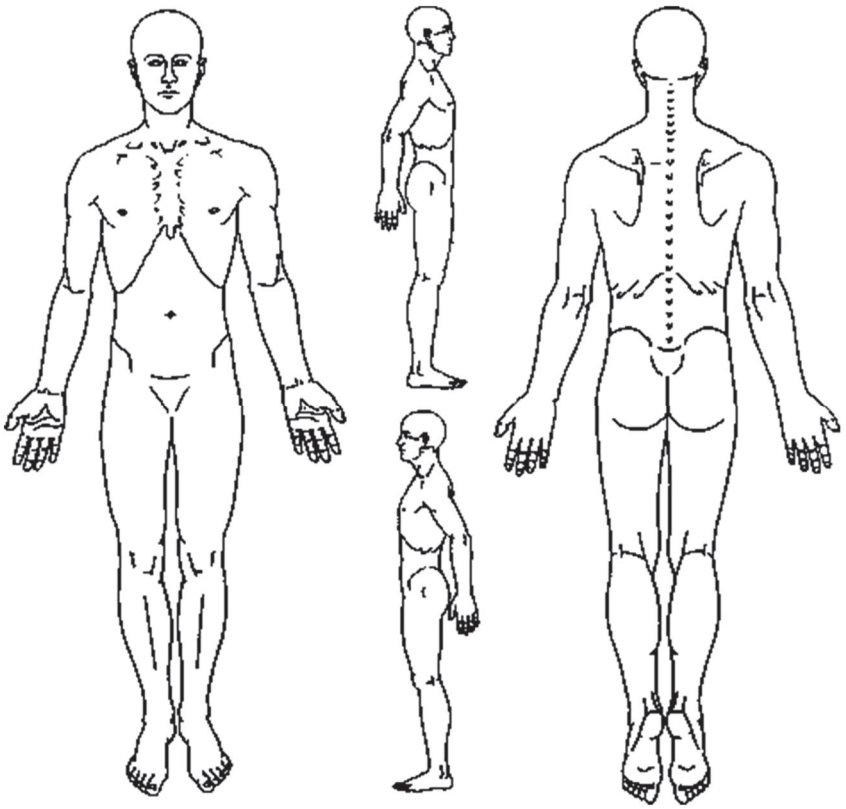
KEYSTONE MEDICAL WELLNESS

PAIN MANAGEMENT

Please fill out if you are having pain.

If not applicable - Skip to Patient Acknowledgment below

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
T	Throbbing
SH	Sharp
TE	Tender
O	Other

0 1 2 3 4 5 6 7 8 9 10

PATIENT ACKNOWLEDGMENT

I certify that the information provided on Pages 1 – 5 is true and accurate to the best of my knowledge.

Patient Printed Name **Patient Signature** **Todays Date**

FINANCIAL POLICY

Welcome

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. 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. 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, ALL major Credit Cards, HSA & FSA accounts**. Keystone Medical Wellness **does not accept insurance** for services rendered. **ALL payments** are due at the time of service. We will not bill any Insurance.

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 be in compliance with Arizona State law and HIPAA regulations, we charge a flat fee of $25.00 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.
Late arrivals -- If you arrive late for a scheduled appointment, you may be asked to reschedule your appointment or wait for an open appointment time on that day's schedule.
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 --If you miss your appointment, you may be charged a $25.00 fee for a missed appointment or a $75.00 fee for a missed procedure. This fee will need to be paid prior to rescheduling. 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 with 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 is not required. The process simplifies payments for you during the check out process. If you have any questions about the card-on-file payment method, please let us know.

My signature below signifies that I have read, understand & will comply with the financial policies and options at Keystone Medical Wellness.

PATIENT PRINTED NAME **PATIENT SIGNATURE** **DATE**