HELPING YOUR BODY HEAL ITSELF

SEDONA REGENERATIVE MEDICINE

WELCOME!

In consideration of our chemically sensitive patients, many of whom become ill when exposed to PERFUMES, COLOGNES, HAIR SPRAYS AND OTHER SCENTED PRODUCTS, as well a heavy CIGARETTE SMOKE, please refrain from wearing any of these when visiting the clinic.

OFFICE HOURS

Our normal business hours are from 8:30am to 5:00pm, Monday through Thursday, and 8:30 to 4:30 pm on Friday, with lunch from 12:30- 1:30. We stop answering the phones at 5:00pm. Our voice-mail answering service will take your calls whenever our lines are busy or we have stepped away from the desk during regular hours. In case of a medical emergency, or you need to reach a doctor you will hear options to assist you.

FEES

The following fees are only general guidelines. Total fees will depend on services rendered.

First comprehensive visit is approximately 45–60 minutes and generally ranges from $150-$250.

problem focused first visits are 20-30 minutes and approximately $108-$161.

Follow-up visits are 15-20 minutes and can range between $75-$110.

Telephone and tele-medicine follow up visits are available, but are not billable to insurance and are paid for at

time of service. Copays, deductibles and administrative fees are due at the time of the visit.

When time permits, return courtesy calls from the doctors will be limited to 3 minutes. Concerns that require more time need an appointment for a phone consultation or an office visit. Your first visit to our clinic will not generally be coded as annual wellness visits. This allows us time to learn about you, your history of health, and any issues you have.

REFERRALS AND PRESCRIPTION REFILLS

Insurance plans are tightening their requirements, therefore every time you need a referral to a specialist, or need a preauthorization for a procedure that was not ordered by your doctor at this office, an appointment may be required for your doctor to initiate that process.

If you run out of refills on your medical prescriptions, call the pharmacy and ask them to fax us a request to renew your Rx. If we have not seen you for six months, you will be asked to schedule

an appointment to reassess your need for that medication. Leave plenty of time particularly if you have a drug plan that may need pre-authorizations.

CANCELLATION

We need 24 hours' notice to cancel your appointment without a charge, otherwise a 35.00 fee will be applied. If you must cancel due to circumstances beyond your control, the fee may be waived.

PAYMENT POLICY

1) Payment at the time of service is required unless PRIOR arrangements have been made.

2) Payment for ALL supplements is REQUIRED at time of purchase.

3) Visa, MasterCard, Discover, American Express, personal checks and cash are all acceptable for of payment.

4) There is a $45 charge for any NSF checks returned to us.

5) If it is determined that you owe a deductible or copay, we will collect that at time of service.

6) There is a 50.00 no show fee for appointments that are not cancelled with a 24-hour notice.

BILLING POLICY

1) Insurance Billing (we file for you):

As a convenience to you, we will gladly bill your insurance company. This service also includes any billings to your secondary insurance. Supplements and any cash procedures will NOT be billed to insurance.

2) Insurance Billing (you file yourself):

Should you choose to bill you own insurance, you will receive a receipt at time of service suitable and sufficient to bill your insurance yourself. Payment in full will be collected at time of service.

3) If your Insurance requires a named PCP (Primary Care Practitioner) please call them in advance of the visit and find out when the effective date will be, and that the proper practitioner is named.

WE CANNOT GUARANTEE YOUR INSURANCE COVERAGE.

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SRM, does not take all insurance, please check with office staff to be sure that you are covered. Cash pay is always an option for any service.

We will do what we reasonably can to furnish whatever is needed, or requested by your insurance company for coverage. However, you are ultimately responsible for settling your account regardless of the type or extent of your insurance coverage. Any unpaid charges will be applied to your account and you will be responsible for payment in full.

Any insurance payments received by this office over and above your current balance will be refunded to you if your account is paid in full. Otherwise, over-payments will be applied to your outstanding balance.

I have read the above and agree to all terms.

Patient Signature_____Date_____

PATIENTS PERSONAL INFORMATION

Today's Date:_____ My appointment is with (Dr.):_____

Please PRINT or write legibly. Complete all sections below.

NAME: Last _____ First_____ Initial_____

ADDRESS_____CITY_____STATE_____ZIP_____

Name you would like to go by, if different from above _____

Name of Spouse_____If Minor, name of parents or guardians_____

Home Phone_____Work Phone_____ Cell _____

Email_____

Age _____ Date of Birth_____ Sex: Male / Female

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Employer_____ Occupation_____ Education_____

Relative or friend who we can contact in an emergency_____ Phone _____

Circle: Asian African American Caucasian Hispanic Native American Hawaiian

Other_____ Preferred language_____

INSURANCE INFORMATION

Insurance Name_____ ID #_____

Group # _____

Insurance address_____

Name of insured_____ Relationship to patient : Self / Spouse / Parent

Referral information: Referred by_____

How did you find us? _____

If you are using insurance for payment of Services: I understand that if arrangements are made for insurance billing and reimbursement, I assign directly to Sedona Regenerative Medicine (SRM) and its providers, any medical benefits to which SRM is entitled as payment for any unpaid balance. It is understood that any moneys received over and above my indebtedness will be refunded when my bill is paid in full. I hereby authorize SRM and its providers to release to my insurance company such information as necessary to secure the payment of benefit. Furthermore, I understand that I am personally responsible for any expenses incurred, including those for which insurance benefits are denied.

Signed_____ Date _____

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Dear Patient,

Financial based decisions are sometimes the most difficult decisions to make, however, given the enormous administrative burden and additional costs being placed on primary care clinics, like ours, we must offset these costs with a small semi-annual charge of $50.00 for a single patient and $75.00 for a family. This will be for all our current and new patients. We are optimistic you will understand.

Thank you,

Forrest D. Lanchbury, M.D., D.V.M.

Medical Director, Sedona Regenerative Medicine

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Primary Care Physician _____

ALLERGIES:

Medication, food or supplement	Reaction (hives, breathing problem, etc)

COMPLAINTS AND CONCERNS:

If you could eliminate 3 health problems what would they be?

1._____

2._____

3._____

Think back to a time you felt well…. When was that?

Did anything cause your health to change for the worse?

What makes you feel worse?

What makes you feel better?

Please list current problems in order of urgency:

Problem	Prior treatment	Result
Example: Reflux	*Eliminate sugar and pasta*	*good*

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MEDICAL HISTORY: (check marks for both past and present conditions)

CARDIOVASCULAR
☐Heart attack
☐Heart murmur
☐Stroke
☐High Cholesterol
☐Irregular heart rate
☐Mitral Valve prolapse
☐High blood pressure
☐Rheumatic fever
☐Other_____

GENITAL AND URINARY SYSTEM
☐Kidney stones
☐Gout
☐Cystitis
☐Frequent urinary tract infections
☐Frequent yeast infections
☐Trouble with erections or sexual dysfunction
Other_____

METABOLIC/ENDOCRINE
☐Type 1 diabetes
☐Type 2 diabetes
☐Low blood sugar (hypoglycemia)
☐Hypothyroidism (underactive thyroid)
☐Hyperthyroidism (overactive thyroid)
☐Polycystic ovary syndrome
☐Infertility
☐Weight gain
☐Weight loss
☐Frequent weight fluctuations
☐Bulimia
☐Anorexia
☐Binge eating disorder
☐Night eating disorder
Other_____

RESPIRATORY DISEASES
☐Asthma

GASTROINTESTINAL
☐Irritable bowel syndrome
☐inflammatory bowel disease
☐Crohn's
☐Ulcerative colitis
☐Gastritis or ulcers
☐GERD (reflux disease)
☐Celiac disease
☐Other_____

JOINT AND MUSCLE PAIN
☐Osteoarthritis
☐Fibromyalgia
☐Chronic pain
☐Temporal mandibular (TMJ)
☐Tendonitis
Other_____

INFLAMMATION/AUTOIMMUNE
☐Chronic Fatigue Syndrome
☐Autoimmune disease_____
☐Rheumatoid arthritis
☐Lupus SLE
☐Immune deficiency disease
☐Herpes-Genital
☐Chronic infection
☐Poor immunity
☐Food allergies
☐Environmental allergies
☐Multiple chemical sensitivity
☐Latex allergy
Other_____

CANCER
☐Lung
☐Breast
☐Colon
☐Ovarian
☐Prostate

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☐Chronic sinusitis
☐Bronchitis
☐Emphysema
☐Pneumonia
☐Tuberculosis
☐Sleep apnea
Other skin disease_____

NEUROLOGICAL
☐Depression
☐Anxiety
☐Bipolar disorder
☐Schizophrenia
☐Headaches
☐Migraines
☐ADD / ADHD
☐Autism

☐Skin
Other_____

SKIN DISEASES
☐Eczema
☐Psoriasis
☐Acne
☐Melanoma
☐Memory problems
☐Parkinson ’s disease
☐Multiple sclerosis
☐ALS
☐Seizures
Other neurological disease_____

PREVENTIVE TESTS AND DATES *Check box if yes and provide date*

☐Full physical exam _____
☐Bone density_____
☐Colonoscopy_____
☐Cardiac stress test_____
☐Upper endoscopy _____
☐EKG_____
☐Hemoccult blood stool test_____
☐Colo-guard stool test_____
☐Ultrasound_____
☐CT scan_____
☐MRI_____

SURGERIES

TYPE DATE

_____

_____

_____

_____

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SERIOUS INJURIES

_____ Back _____Head_____Neck____Broken bones_____Other_____

HOSPITALIZATIONS

Date Reason

_____

_____

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												

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Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

What is the attitude of those close to you about your illness? ! Supportive ! Non-supportive

Please indicate the occupation of your parents during your childhood:

_____

_____

IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against the following

☐ Smallpox
☐ Tetanus
☐Diphtheria
☐ Pertussis
☐Polio (oral)
☐Polio (Injection)
☐Mumps
☐Measles
☐ Rubella (German measles)
☐ Typhoid
☐Cholera

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Obstetrics: Pregnancies___Caesarean_____Vaginal deliveries_____Miscarriage _____ Abortion_____Living Children_____ Post partum depression___Toxemia___ Gestational diabetes_____Baby over 8 pounds_____Currently Breast feeding For how long?_____

GYNECOLOGICAL HISTORY

Age at 1st period:_____Menses Frequency:_____Length:_____Pain: ☐Yes ☐No Clotting: ☐Yes ☐No Has your period skipped?_____For how long? Last Menstrual Period:_____Do you currently use contraception? ☐Yes ☐No If yes, what type do you use?_____ Have you ever used hormonal contraception? ☐Yes ☐No If yes, what ☐ Birth control pills ☐ Patch ☐ Nuva Ring How long?_____Are you using the pill now? ☐ Yes ☐ No Did taking the pill agree with you? ☐Yes ☐ No
In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, headaches, or irritability (PMS)? ☐Yes ☐ No Last Mammogram/Date_____Breast Biopsy/Date_____Last PAP Test/Date:_____☐Normal ☐ Abnormal Last Bone Density/Date:_____Results: ☐High ☐ Low ☐Within normal range Are you in menopause? ☐Yes ☐No Age at Menopause_____Do you take: ☐ Estrogen ☐Ogen ☐ Estrace ☐ Premarin Other_____☐ Progesterone ☐Provera Other_____How long have you been on hormone replacement? _____

Nutrition History:

Present Weight:_____Height (no shoes):_____Desired Weight: _____
Weight at 20 years of age:_____Weight one year ago: _____
What has been your maximum lifetime weight (non-pregnant) and when?_____
Do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never
Have you made any changes in your eating habits because of your health? Yes No_____
Describe changes_____
Do you follow a special diet or nutritional program? Yes No_____

Previous diets you have followed:

_____

_____

Give dates and results of your weight loss:

_____

_____

Diet you follow now *Check all that apply*

☐ Low fat ☐ Low Sodium ☐ Vegan
☐ Low carbohydrate ☐ Diabetic ☐ Gluten restricted

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☐ High Protein ☐ Vegetarian ☐ Paleo
☐ Blood type ☐ Other_____

Do you avoid any foods? ☐ Yes ☐ No If yes. Types and reason_____
_____

If you could only eat four foods a week what would they be?_____
Do you cook? ☐ Yes ☐ No If no who does the cooking?
How many meals do you eat out a week? 0 1 2 3 4 > 5
What would be the most important thing you could change about your diet that would make the biggest difference in your health? _____

SMOKING
Currently smoking ☐ Yes ☐ No If yes how many years?_____Packs per day? _____
How many times have you tried to quit?_____Second Hand Smoke Exposure? _____
Chewing Tobacco ☐ Yes ☐ No If yes how long_____ Amount per day_____
ALCOHOL INTAKE
Currently drinking alcohol? ☐ Yes ☐ No If yes how many drinks per day_____
OTHER SUBSTANCES
Caffeine Intake: ☐ Yes ☐ No Coffee cups per day_____Tea cups per day_____Energy drinks_____
Sodas ☐ Yes ☐ No Regular amount per day_____ Diet amount per day_____What's your favorite soda?_____Are you currently using recreational drugs? ☐ Yes ☐ No If yes what types? _____
Do you have a Medical Marijuana card? ☐ Yes ☐ No If yes for what heath condition_____
Have you ever used IV or inhalation drugs? ☐ Yes ☐ No

EXERCISE
Current exercise program (List type of program and number of sessions per week, and duration'

Activity	**Type**	**Frequency per week**	**Duration in minutes**
Stretching			
Cardio/Aerobics			
Strength			
Other (Yoga, plilates, etc.)			
Sports or lesure activities (Golf, Tennis, Hiking, etc.			

Sleep

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Do you get enough sleep? Y N How many hours/night? _____
Do you have trouble falling asleep? Y N Do you awaken well rested? Y N
Do you wake in the night? Y N If yes, how often? _____
Do you snore? Y N Has anyone told you that you stop breathing in your sleep? Y N

Roles/ Relationships

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnership ☐ Widow

List Children: Childs Full Name	Age	Gender

Who is living in the household? Number_____Names_____
Their employment/Occupations_____

Resources for emotional support? Check all that apply ☐ Spouse ☐ Family ☐ Friends
☐ Religious/Spiritual ☐ Pets ☐ Other_____
Are you satisfied with your sex life? ☐ Yes ☐ No
Are their problems with your Marriage, Social life, Job, School, Close friends, Sex, Parents, Boyfriend / Girlfriend? ☐ Yes ☐ No If yes what are the problems?

_____
_____

How is your overall attitude? ☐ Good ☐ OK ☐ Bad

Review of systems

GENERAL	**NOW**	**PAST**	**EYES**	**NOW**	**PAST**
Fatigue	☐	☐	Blurry	☐	☐
Fever	☐	☐	Double	☐	☐
Weakness	☐	☐	Pain	☐	☐
Weight Loss	☐	☐	Floaters	☐	☐
EARS	**NOW**	**PAST**	**NOSE**	**NOW**	**PAST**
Hearing Loss	☐	☐	Blee ding	☐	☐
Eara che	☐	☐	Loss of Smell	☐	☐
Discharge	☐	☐	Obstruction	☐	☐
Ringing	☐	☐	Sinus problem	☐	☐
THROAT	**NOW**	**PAST**	**HEAD**	**NOW**	**PAST**
Soreness	☐	☐	Headaches	☐	☐
Swallowing	☐	☐	Injuries	☐	☐
Infections	☐	☐	Dizziness	☐	☐

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SKIN	NOW	PAST	MOUTH	NOW	PAST
Rashes	☐	☐	Ba d breath	☐	☐
Itching	☐	☐	Bleeding Gums	☐	☐
Dryness	☐	☐	Ulcers	☐	☐
Mole Changes	☐	☐	Dental Problem	☐	☐
Sores	☐	☐	Loss of Taste	☐	☐
CHEST	**NOW**	**PAST**	**BREASTS**	**NOW**	**PAST**
Short Breath	☐	☐	Lumps	☐	☐
Cough	☐	☐	Pain	☐	☐
Chest Pain	☐	☐	Discharge	☐	☐
Wheezing	☐	☐			
HEART	**NOW**	**PAST**	**GASTROINT**	**NOW**	**PAST**
Cold Extremity	☐	☐	Abdominal Pain	☐	☐
Ankle Edema	☐	☐	Nausea	☐	☐
Murmur	☐	☐	Vomiting	☐	☐
Varicosity	☐	☐	Diarrhea	☐	☐
Blood Clots	☐	☐	Constipation	☐	☐
Palpitations	☐	☐	Bloody Stool	☐	☐
GENITOURINE	**NOW**	**PAST**	Black Stool	☐	☐
Urine Hesitancy	☐	☐	Jaundice	☐	☐
Incontinence	☐	☐	Heartburn	☐	☐
Urgency	☐	☐	Hemorrhoids	☐	☐
Frequency	☐	☐	Belching	☐	☐
Kidney Stones	☐	☐	Loss of Appetite	☐	☐
WOMAN	**NOW**	**PAST**	**MAN**	**NOW**	**PAST**
Painful Sex	☐	☐	Impotence	☐	☐
Discharge	☐	☐	Loss of Libido	☐	☐
Irreg Periods	☐	☐	Dribbling	☐	☐
Hot Flashes	☐	☐	**BLOOD/ LYMPH**		
Loss of Libido	☐	☐	Bruising	☐	☐
Spotting	☐	☐	Bleeding	☐	☐
Heavy Flow	☐	☐	Anemia	☐	☐
UTI	☐	☐	Swollen Glands	☐	☐
ENDOCRINE	**NOW**	**PAST**	**MUSCULOSK**	**NOW**	**PAST**
Heat Intolerant	☐	☐	Joint Stiffness	☐	☐
Cold Intolerant	☐	☐	Joint Pain	☐	☐
Weight Loss	☐	☐	Muscle Pain	☐	☐
Weight Gain	☐	☐	Muscle Cramps	☐	☐
Hair Changes	☐	☐	Muscle Spasms	☐	☐
PSYCHOLOGIC	**NOW**	**PAST**	**NEUROLOGIC**	**NOW**	**PAST**
Anxiety	☐	☐	Numbness	☐	☐
Depression	☐	☐	Tingling	☐	☐
Loss of Interest	☐	☐	Seizures	☐	☐
Phobias	☐	☐	Incoordination	☐	☐
Suicidal Ideas	☐	☐	Memory Loss	☐	☐

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Drugs	☐	☐	Vertigo	☐	☐
Alcoholism	☐	☐	Difficult Speech	☐	☐
Hallucinations	☐	☐	Paralysis	☐	☐
Insomnia	☐	☐	Hand Tremors	☐	☐

MEDICATION LOG

Please indicate the type of medications you are taking NOW or have RECENTLY. Include non-prescription drugs.

Medication Name	Dose	Frequency	Start Date	Reason for use

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Nutritional supplement/ vitamin/ Herbs and homeopathy LOG

Supplement and brand	Dose	Frequency	Start Date	Reason for use