



10190 Critzer Shop Road, Afton, Virginia 22920  
(434) 361-1896

## PATIENT REGISTRATION FORM

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male  Female  Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: Single  Married  Separated  Divorced  Widowed

Spouse's Name: \_\_\_\_\_

Spouse's Work Phone: \_\_\_\_\_ Spouse's Mobile Phone: \_\_\_\_\_

Emergency Contact(s): \_\_\_\_\_

Emergency Contact Phone(s): \_\_\_\_\_

How were you referred to us?

Internet

Another Patient (Name): \_\_\_\_\_

Another Doctor (Name): \_\_\_\_\_

Other: \_\_\_\_\_

Our website

Another website: \_\_\_\_\_

Blog: \_\_\_\_\_

\_\_\_\_\_

# HEALTH HISTORY QUESTIONNAIRE

## FAMILY HISTORY

For each member of your family, read down the list and put a check in the boxes that apply. Put one check for each relative having a certain disease, e.g., put 3 checks in Grandparents - Stroke, if 3 of your grandparents suffered strokes. Indicate age only if deceased.

	Father	Mother	Brothers	Sisters	Spouse	Children	Grandparents	Aunts/Uncles
Age (at death only)								
Cause of Death								
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Seizures								
Allergies / Asthma								
Anemia / Blood Disease								
Mental Illnesses / Autism								
Genetic Disease								
Alcoholism / Drug Abuse								
Kidney Disease								
Arthritis								
Autoimmune Disease								
Thyroid Disease								
Venereal Disease								
Malaria or Tuberculosis								

## PERSONAL HISTORY

Put a check in the box next to any of the following that you now or have ever had:

Q Measles	Q Chronic Sinusitis	Q Serious infection	Q Hay fever	Q Serious injury	Q other
Q Mumps	Q Bronchitis	Q Malaria	Q Frequent Colds	Q Alcoholism or Drug Abuse	_____
Q Chicken pox	Q Pneumonia	Q Yellow jaundice	Q Neuritis or Neuralgia	Q Nervous breakdown or Psychosis	_____
Q Polio	Q Pancreatitis	Q Liver disease/Hepatitis	Q Sciatica	Q Hyperactivity and/or A.D.D.	_____
Q Diphtheria	Q Ulcers	Q Skin disorders	Q Low Back Pain	Q Heart trouble	_____
Q Small pox	Q Diverticulosis	Q Kidney disease or Stones	Q Anemia or Blood disease	Q Hypertension/High Blood Pressure	_____
Q Meningitis	Q Hernias	Q Venereal disease	Q Diabetes	Q Stroke	_____
Q Scarlet fever	Q Hemorrhoids	Q Tuberculosis	Q Hormonal disorders	Q Gall Bladder disease	_____
Q Rheumatic fever	Q Bone/Joint disease	Q Concussion/Head injury	Q Thyroid disease	Q Rabies	_____
Q Genetic disease	Q Cancer	Q Migraines/Headaches	Q Anxiety	Q Reaction to drugs, vaccines, transfusions	_____
Q Chronic Fatigue	Q Seizures/Epilepsy	Q Neurological disorders	Q Depression	To what?	

## MAJOR HOSPITALIZATIONS

If you have ever been hospitalized for any serious illness or operation, write in your most recent hospitalization below. Use the reverse side if needed. (Do not include normal pregnancies)

Year	Operation or Illness	Physician's Name	City and State

Please list the name and address of any other physicians who have treated you in the past year and the problem for which you were treated (Do not include visits for cold, flus or other minor acutes)

Physician's Name	Address	Problem

## MEDICATIONS

Indicate those medicines you are presently taking or which you have taken in the past. Please give the name and dosage of all current medicines.

Present	Past		Present	Past	
		Antibiotics			Diabetes medicines
		Pain medicine			Arthritis medicines
		Diuretics (water pills)			Diet pills
		Sedatives			Antacids or laxatives
		Blood pressure medicines			Birth control pills
					Hormones
		Heart medicines			Antimalarial drugs
		Thyroid medicines			Antituberculosis drugs
		Aspirin			Allergy desensitization
		Vitamins & Herbs			Other

## DRUG ALLERGIES

Please list any and all medicines you are allergic to, e.g., penicillin, sulfa drugs, other antibiotics, aspirin, codeine, etc.

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## TESTS AND IMMUNIZATIONS

Check those tests and immunizations which you have had. Enter the year when you last were given the tests or shots.

Year	Year	Year	Year
	Chest X-Ray		Colonoscopy/Sigmoidoscopy
	Kidney X-Ray		PAP smear
	G.I. Series		Nutritional Analysis
	Colon X-Ray		Polio series
	Electrocardiogram		Measles, mumps, rubella
	TB test		HIV vaccine
	CT or MRI scan		Ultrasound
			DPT
			Tetanus
			Flu shot
			Pneumonia shot
			Other

## HEALTH FACTORS

Please check those items below that apply.

Yes	No	Do you drink or use?	Yes	No	
		Coffee?      ___ cups/day			Do you use an electric blanket?
		Tea?            ___ cups/day			Do you have silver-mercury amalgams in your mouth?
		Sodas?         ___ cans/day			Do you exercise regularly?
		Beer?          ___ cans/day			How much?
		Wine?         ___ glasses/day			Do you meditate regularly?
		Other alcohol? ___ glasses/day			Do you use "recreational" drugs, e.g. cocaine, LSD, marijuana, etc.?
		Cigarettes?   ___ packs/day			Have you any known environmental sensitivities or past or present toxic chemical exposure?
		Cigars?        ___ cigars/day			Please describe:
		Pipe?         ___ bowls/day			
		Chew tobacco?			
		Snuff?			

**Please describe your emotional nature and personality characteristics, especially the major issues in your life:**

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# HEALTH QUESTIONNAIRE

If you have recently been bothered with these problems check YES.

Yes	No	Yes	No	Yes	No			
<input type="checkbox"/>	<input type="checkbox"/>	frequent or severe headache	<input type="checkbox"/>	<input type="checkbox"/>	recurring indigestion	<input type="checkbox"/>	<input type="checkbox"/>	aching muscles or joints
<input type="checkbox"/>	<input type="checkbox"/>	neck pains	<input type="checkbox"/>	<input type="checkbox"/>	frequent belching	<input type="checkbox"/>	<input type="checkbox"/>	swollen joints
<input type="checkbox"/>	<input type="checkbox"/>	neck lumps or swelling	<input type="checkbox"/>	<input type="checkbox"/>	nausea	<input type="checkbox"/>	<input type="checkbox"/>	back or shoulder pains
<input type="checkbox"/>	<input type="checkbox"/>	loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	vomiting	<input type="checkbox"/>	<input type="checkbox"/>	weakness in arms or legs
<input type="checkbox"/>	<input type="checkbox"/>	dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	pain in abdomen	<input type="checkbox"/>	<input type="checkbox"/>	painful feet
<input type="checkbox"/>	<input type="checkbox"/>	blackouts/fainting	<input type="checkbox"/>	<input type="checkbox"/>	bloated abdomen	<input type="checkbox"/>	<input type="checkbox"/>	trembling
<input type="checkbox"/>	<input type="checkbox"/>	wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	constipation	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	loose bowels	<input type="checkbox"/>	<input type="checkbox"/>	leg cramps
<input type="checkbox"/>	<input type="checkbox"/>	eyesight worsening	<input type="checkbox"/>	<input type="checkbox"/>	black stools	<input type="checkbox"/>	<input type="checkbox"/>	skin problems
<input type="checkbox"/>	<input type="checkbox"/>	see double	<input type="checkbox"/>	<input type="checkbox"/>	gray or whitish stools	<input type="checkbox"/>	<input type="checkbox"/>	scalp problems
<input type="checkbox"/>	<input type="checkbox"/>	see halos or lights	<input type="checkbox"/>	<input type="checkbox"/>	pain in rectum	<input type="checkbox"/>	<input type="checkbox"/>	itching or burning skin
<input type="checkbox"/>	<input type="checkbox"/>	eye pains or itching	<input type="checkbox"/>	<input type="checkbox"/>	itching rectum	<input type="checkbox"/>	<input type="checkbox"/>	bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	watering eyes	<input type="checkbox"/>	<input type="checkbox"/>	blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	nervousness or anxiety
<input type="checkbox"/>	<input type="checkbox"/>	hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	nervous with strangers
<input type="checkbox"/>	<input type="checkbox"/>	earaches	<input type="checkbox"/>	<input type="checkbox"/>	involuntary escape of urine	<input type="checkbox"/>	<input type="checkbox"/>	nail biting
<input type="checkbox"/>	<input type="checkbox"/>	running ears	<input type="checkbox"/>	<input type="checkbox"/>	burning on urination	<input type="checkbox"/>	<input type="checkbox"/>	difficulty making decisions
<input type="checkbox"/>	<input type="checkbox"/>	noises in ears	<input type="checkbox"/>	<input type="checkbox"/>	brown, black or bloody urine	<input type="checkbox"/>	<input type="checkbox"/>	lack of concentration
<input type="checkbox"/>	<input type="checkbox"/>	dental problems	<input type="checkbox"/>	<input type="checkbox"/>	weak urine stream	<input type="checkbox"/>	<input type="checkbox"/>	absentminded/loss of memory
<input type="checkbox"/>	<input type="checkbox"/>	sore or bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	difficulty starting urine	<input type="checkbox"/>	<input type="checkbox"/>	lonely or depressed
<input type="checkbox"/>	<input type="checkbox"/>	sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	constant urge to urinate	<input type="checkbox"/>	<input type="checkbox"/>	frequent crying
<input type="checkbox"/>	<input type="checkbox"/>	congested nose	<input type="checkbox"/>	<input type="checkbox"/>	<b>(MEN ONLY)</b>	<input type="checkbox"/>	<input type="checkbox"/>	hopeless outlook
<input type="checkbox"/>	<input type="checkbox"/>	running nose	<input type="checkbox"/>	<input type="checkbox"/>	burning or discharge	<input type="checkbox"/>	<input type="checkbox"/>	difficulty relaxing
<input type="checkbox"/>	<input type="checkbox"/>	sneezing spells	<input type="checkbox"/>	<input type="checkbox"/>	lumps or swelling on testicles	<input type="checkbox"/>	<input type="checkbox"/>	worry a lot
<input type="checkbox"/>	<input type="checkbox"/>	head colds	<input type="checkbox"/>	<input type="checkbox"/>	painful testicles	<input type="checkbox"/>	<input type="checkbox"/>	frightening dreams or thoughts
<input type="checkbox"/>	<input type="checkbox"/>	nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<b>(WOMAN ONLY)</b>	<input type="checkbox"/>	<input type="checkbox"/>	feeling desperation
<input type="checkbox"/>	<input type="checkbox"/>	sore throat	<input type="checkbox"/>	<input type="checkbox"/>	a missed period	<input type="checkbox"/>	<input type="checkbox"/>	shy or sensitive
<input type="checkbox"/>	<input type="checkbox"/>	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	dislike criticism
<input type="checkbox"/>	<input type="checkbox"/>	hoarse voice	<input type="checkbox"/>	<input type="checkbox"/>	bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	angered easily
<input type="checkbox"/>	<input type="checkbox"/>	wheezing or gasping	<input type="checkbox"/>	<input type="checkbox"/>	tension or pain before periods	<input type="checkbox"/>	<input type="checkbox"/>	annoyed by little things
<input type="checkbox"/>	<input type="checkbox"/>	frequent coughing	<input type="checkbox"/>	<input type="checkbox"/>	heavy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	family problems
<input type="checkbox"/>	<input type="checkbox"/>	cough up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	bearing down feeling	<input type="checkbox"/>	<input type="checkbox"/>	problems at work
<input type="checkbox"/>	<input type="checkbox"/>	cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	sexual difficulties
<input type="checkbox"/>	<input type="checkbox"/>	chest colds	<input type="checkbox"/>	<input type="checkbox"/>	genital irritation	<input type="checkbox"/>	<input type="checkbox"/>	considered suicide
<input type="checkbox"/>	<input type="checkbox"/>	rapid or skipped heartbeats	<input type="checkbox"/>	<input type="checkbox"/>	pain on intercourse	<input type="checkbox"/>	<input type="checkbox"/>	sought psychiatric help
<input type="checkbox"/>	<input type="checkbox"/>	chest pains	<input type="checkbox"/>	<input type="checkbox"/>	swelling or lumps in breasts	<input type="checkbox"/>	<input type="checkbox"/>	loss or gain in weight
<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath with normal activity	<input type="checkbox"/>	<input type="checkbox"/>	painful breasts	<input type="checkbox"/>	<input type="checkbox"/>	often feel warmer or colder than others
<input type="checkbox"/>	<input type="checkbox"/>	swollen feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>	___ # of pregnancies	<input type="checkbox"/>	<input type="checkbox"/>	loss of appetite
			<input type="checkbox"/>	<input type="checkbox"/>	___ # of births	<input type="checkbox"/>	<input type="checkbox"/>	always hungry
			<input type="checkbox"/>	<input type="checkbox"/>	___ miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	armpits or groin swelling
			<input type="checkbox"/>	<input type="checkbox"/>	___ premature births	<input type="checkbox"/>	<input type="checkbox"/>	unusual fatigue or weariness
			<input type="checkbox"/>	<input type="checkbox"/>	___ cesareans	<input type="checkbox"/>	<input type="checkbox"/>	difficulty sleeping
			<input type="checkbox"/>	<input type="checkbox"/>	___ abortions	<input type="checkbox"/>	<input type="checkbox"/>	fever or chills
Comments or Special Problems:						<input type="checkbox"/>	<input type="checkbox"/>	motion sickness
						<input type="checkbox"/>	<input type="checkbox"/>	excessive sweating
						<input type="checkbox"/>	<input type="checkbox"/>	night sweats
						<input type="checkbox"/>	<input type="checkbox"/>	hot flashes



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## **Contract for Integrative & Regenerative Medical Services**

Dear Patient:

Integrative & Regenerative Medicine are distinct, specialized types of medical services apart from allopathic or conventional medical practice. Due to the unique office visit and the extraordinary amount of time and effort required by Dr. Fleisher to conduct the Integrative & Regenerative Medical examination and interview, the charge may not be adequately reimbursed by health insurance.

**Please note:** We are currently restricted from billing for Integrative & Regenerative Medical services to Medicare, Medicaid, Blue Cross/Blue Shield and other health insurers. Also, Medicare and Medicaid patients cannot personally file for reimbursement from Medicare and Medicaid.

You will be fully responsible for the payment of fees at the time that Integrative & Regenerative Medical services are rendered. An invoice with the appropriate coded billing information will be provided for submittal to your insurance company for your reimbursement.

Please sign the following statement, which will serve as a billing contract for Integrative & Regenerative Medical services.

**“I understand that I am responsible for the full payment of fees for Integrative & Regenerative Medical consultations at the time that services are rendered.”**

Signed: \_\_\_\_\_  
Patient, Parent or Guardian

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_



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## Patient Acknowledgement of Receipt/Review of the Notice of Privacy Practices

PATIENT NAME: \_\_\_\_\_

By signing this form, I am acknowledging my receipt and/or review of the posted Notice of Privacy Practices of the Center for Integrative & Regenerative Medicine. I have been given the right to review the Notice of Privacy Practices prior to signing this form.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Name of Legal Guardian (if applicable)

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Date

**Please kindly complete and return with the Patient Registration Form**



10190 Critzers Shop Rd., Afton, Virginia 22920  
(434) 361-1896, Fax: (540) 456-6161  
[www.cirm1.org](http://www.cirm1.org)

## POLICIES & FEES

### **PLEASE NOTE:**

- 1) A 50% deposit is required for all new office or phone consultations. This is collected at the time that the appointment is scheduled.
- 2) If your new appointment is cancelled within 72 hours in advance, then the deposit for your initial consultation is refundable minus an administrative fee of \$75.00. If your new appointment is cancelled after 72 hours prior to the scheduled date, then the deposit for your initial consultation is forfeited.
- 3) Changes to any confirmed, scheduled, follow-up office and phone consultations must be made 48 hours or more prior to the appointment. Follow-up office and phone consultations that are missed without prior notice being received by our staff will be charged an administrative fee of 75% of the appointment fee.
- 4) For Tuesday appointments, the cancellation notice must be received on the prior Thursday.
- 5) In the event of inclement weather, if you choose not to come to the office, then your confirmed, scheduled consultation will be provided via telephone. If you decline this service, you will be charged an administrative fee of 75% of the appointment fee.

### **Fee Schedule**

Initial, 1 hour Integrative Medicine consultation is \$475.00

2½ hour Constitutional Homeopathic Medical consultation is \$1,295.00

Follow-up consultations are \$175.00 (½ hour or less as needed)

An additional charge of \$50.00 per ¼ hour will apply for a follow-up consultation over ½ hour

Additional fees will apply for IV Therapies, Joint Regeneration Therapy, Stem Cell Therapy, special laboratory testing, medications and/or supplements

### **Billing**

Payment is due in full at the time that services are provided. We do not bill patients or insurance companies. You will be given a super-bill with all fees and pertinent coding. You will need to contact your insurance company and ask how they would like you to submit the super-bill for reimbursement directly to you.

### **Medicare**

Medicare does not cover alternative and complementary medicine, including Homeopathy, Naturopathy, IV therapies, specialized testing, supplements, etc. As a result, our office cannot and does not accept Medicare insurance. Most private insurance companies tend to follow Medicare policies and will also not cover alternative, complementary medical services. You will need to read your insurance policy very carefully and be familiar with its terms and conditions.

### **Phone Calls**

We realize that your phone calls are an important part of our service to you. We will make every effort to return your call as soon as possible. However, we are a very busy medical office, and if you do not hear from us, please call back.

'After-hours medical care' phone consultation services will be charged a minimum of \$50.00 after the initial, free, three minutes.

**I, the undersigned, acknowledge and accept the policies and fees of CIRM:**

**Signed:** \_\_\_\_\_

**Dated:**