CIRM
CENTER FOR
INTEGRATIVE & REGENERATIVE MEDICINE

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	Our website
Another Patient (Name):	Another website:
Another Doctor (Name):	Blog:
Other:	

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.

10190 Critzers Shop Rd., Afton, Virginia 22920
(434) 361-1896, Fax: (540) 456-6161
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: