



PATIENT DEMOGRAPHIC INFORMATION SHEET

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Gender: _____

Patient Phone: _____ Email Address: _____

Referring Doctor: _____

Address: _____

Primary Doctor: _____

Address: _____

Primary Insurance: _____ Claim/ID: _____

Policy Holder/Relationship to Holder: _____ Date of Birth: _____

Address: _____ Phone: _____

Secondary Insurance: _____ Claim/ID: _____

Policy Holder/Relationship to Holder: _____ Date of Birth: _____

Address: _____ Phone: _____

Patient Signature: _____

*** Please bring the following to your appointment: Photo I.D. and insurance card, complete list of medications, vitamins/supplements you are taking, and any labs or testing you've had in the last 6 months***



MEDICAL HISTORY QUESTIONNAIRE

Height: _____ Weight: _____ Age: _____ Sex: _____

1. Are you in good health at this present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No

If yes, please explain _____

3. ALLERGIES:

Do you have any allergies to medications and/or latex, foods, environmental etc.? Yes No

If yes, please explain and list the interactions _____

4. Medications:

Are you currently taking any medications? Yes No

If yes, please list the name, dosage, and frequency. _____

5. Do you have history of:

Heart Attack Chest Pain Arrhythmia Palpitations

Abnormal EKG Heart Murmur Shortness of breath with exertion

6. Have you ever been told you have diabetes? Yes No

If yes, please explain _____

7. Do you have leg:

Pain Swelling Tingling Burning Numbness

8. Do you have shortness of breath at rest? Yes No

Do you have shortness of breath at mild exertion? Yes No

9. In the past 2-4 weeks have you had abdominal pain? Yes No

If yes, check all that apply:

Tenderness Nausea Vomiting Cramping Diarrhea Constipation Bloating

10. Past Medical History (please check all that apply):

- Alcohol Abuse Anemia Arthritis Bleeding Disorder Blood Transfusion Constipation
 - Cancer Chronic Fatigue Drug Abuse Diabetes Eating Disorder Frequent Headaches
 - Gallbladder Disease Gout Heart Disease Heart Valve Disorder High Cholesterol
 - High Blood Pressure Kidney Disease Liver Disease Lung Disease Osteoporosis
 - Psychiatric Illness Rheumatic Fever Sexually Transmitted Diseases Stroke Seizures
 - Swelling of feet Thyroid Disease Ulcers Other: _____
-

11. Surgical History:

Have you undergone any surgical procedures? Yes No

If yes, please list surgeries/procedures and their approximate dates _____

12. Family Medical History:

Please check all that apply along with which family member it applies to.

- Alcohol Abuse _____ Anemia _____ Arthritis _____ Bleeding Disorder _____
- Blood Transfusion _____ Constipation _____ Cancer _____ Chronic Fatigue _____
- Drug Abuse _____ Diabetes _____ Eating Disorder _____
- Frequent Headaches _____ Gallbladder Disease _____ Gout _____
- Heart Disease _____ Heart Valve Disorder _____ High Cholesterol _____
- High Blood Pressure _____ Kidney Disease _____ Liver Disease _____
- Lung Disease _____ Osteoporosis _____ Psychiatric Illness _____
- Rheumatic Fever _____ Sexually Transmitted Diseases _____ Stroke _____
- Swelling of feet _____ Thyroid Disease _____ Ulcers _____
- Other: _____

13. Social History (please check all that apply):

What is your occupational status? Full time Part time Retired Student Disabled

Tobacco History: Current Smoker; everyday Never Socially Vape

Smokeless Tobacco Former Smoker (list length of time): _____

Do you drink alcohol? Yes No

If yes, please list what kind and how often: _____

Have you ever used any illicit drugs? Yes No

If yes, please check all that apply: Never Marijuana Use Cocaine Use Heroin Use

14. Health Maintenance:

Please list approximate dates for each of the following below:

Colonoscopy: ___/___/___ Mammogram: ___/___/___

Stress Test: ___/___/___ Pap Smear: ___/___/___ PSA Test: ___/___/___

Bone Density Scan (DEXA): ___/___/___ Echocardiogram: ___/___/___ EKG: ___/___/___

Women Only:

Have you ever been pregnant? Yes No

If yes, please list how many pregnancies and/or miscarriages you've had: _____

First day of your last menstrual cycle: ___/___/___

Nature of menstrual cycles: Regular Irregular Light Normal Heavy

More than 1 time per month

When you have your cycle, does it take away from your normal daily activities? Yes No

If yes, please explain: _____

Are you currently using birth control? Yes No

If yes, please explain the type and dosage: _____

Are you currently on Hormone Replacement Therapy? Yes No

If yes, please explain what type and dosage: _____

15. What is your desired weight? _____

16. What is the main reason for your decision to lose weight? _____

17. What was your weight 1 year ago? _____ 5 years ago? _____ Maximum weight? _____

18. When did you begin gaining excessive weight? 1-12 months ago 1-2 years ago 3+ years ago

19. Have you ever taken an appetite suppressant?

If yes, please list the medication and dosage: _____

20. Please check all the diet programs that you have followed/tried and if they were successful:

Weight Watchers: Yes No

Low-Fat: Yes No

Jenny Craig: Yes No

Mediterranean: Yes No

OptiFast: Yes No

NutriSystem: Yes No

Atkins: Yes No

Medifast: Yes No

Other: Yes No

If yes, please explain which programs: _____

21. How often do you eat out? 1-2 times weekly 2-5 times weekly 5 or more times weekly

Do you snack in between meals? Yes No

If yes, check all that apply: Morning Between Meals Evening

22. What foods do you crave? _____

23. Do you drink any of the following please check and list how many per week:

Coffee: _____ Water: _____

Sweet-Tea: _____ Non-Sweet Tea: _____

Soda: _____ Diet Soda: _____

24. Do you use artificial sweeteners? Yes No

If yes, check all that apply: Saccharine Equal Splenda Stevia Truvia

Just like sugar

25. Activity Level:

Inactive- No regular physical activity with a sit-down job

Light Activity- No organized physical activity during leisure time

Moderate Activity- Occasionally involved in activities such as weekend golf, tennis, jogging, swimming, or cycling

Heavy Activity- Consistent lifting, stair climbing, heavy construction, or regular participation in jogging, swimming, or cycling.

Vigorous Activity- Participation in extensive physical exercise for at least 60 minutes per session 4 times per week

26. Has your doctor ever said that you have a heart condition and you should only do physical activity when recommended? Yes No

27. Do you feel pain in your chest when you do physical activity? Yes No

28. In the past month have you had chest pain when you were **not** doing physical activity? Yes No

29. Do you lose your balance because of dizziness or have you ever lost consciousness? Yes No

30. Do you have a bone or joint problem (back, knee, hip. etc.) that could be made worse by a change in physical activity? Yes No

31. Is your doctor currently prescribing medication for blood pressure or heart condition? Yes No

32. Do you know of any other reason why you should not do physical activity? Yes No

If yes, please explain: _____

33. Have you ever lost vision in one or both eyes that was not permanent? Yes No

Double Vision? Yes No

34. Have you ever had hearing loss, speech difficulty, or intermittent numbness or loss of movement of a limb? Yes No

35. Are you currently taking any supplements?

If yes, please list: _____

36. Please list all foods that have caused problems for you, if any: _____

37. Have you ever had an anaphylactic reaction (severe allergic reaction that needed treatment right away)? Yes No

If yes, please explain to what: _____

38. Have you ever been diagnosed with any of the following:

Asthma Urticaria (hives, swelling on surface of skin) Rhinitis (chronic running nose)

Venom Allergy (insects, snakes, bees, fire ants) Medication Allergies

Angioedema (hives/swelling under the skin) Latex Allergy

Eczema (itchy, red, cracked inflamed and/or rough skin)

39. Do you know if your family has history of allergies? Yes No

If yes, please list below and who the allergies belong to: _____

40. Do you ever experience any of the following symptoms?

Digestive Tract

- | | |
|-----------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Belching/Bloating | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Abdominal Distention | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Gas (rectal) | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Stomach Pains | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Heartburn, acid reflux, indigestion |
| <input type="checkbox"/> Mucousy Stools | |

Head

- | | |
|------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Headedness |
| <input type="checkbox"/> Faintness | <input type="checkbox"/> Headaches |

Mouth & Throat

- | | |
|--------------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Chronic coughing | <input type="checkbox"/> Gagging |
| <input type="checkbox"/> Clear throat often | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Swollen tongue, lips, or gums | |

Joint Muscles

- | | |
|----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Feeling of weakness | <input type="checkbox"/> Limited movement |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Stiffness |

Respiratory

- | | |
|------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Asthma/ bronchitis- chronic | <input type="checkbox"/> Chest congestion |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Shortness of breath resting or with mild exertion |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Excessive mucous |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Sneezing attacks | <input type="checkbox"/> Stuffy nose |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Postal nasal drip |
| <input type="checkbox"/> Nasal polyps | |
| <input type="checkbox"/> Sinus pressure or pain | |

Ears

- | | |
|------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Itchy Ears |
| <input type="checkbox"/> Ringing in ears | |

Eyes

- Blurred Vision
- Itchy Eyes
- Swollen eyelids
- Dark circles
- Stick eyelids
- Watery eyelids

Weight

- Binge eating
- Cravings
- Underweight
- Night eating
- Compulsive eating
- Excessive weight
- Water retention

Skin

- Acne
- Eczema (red, dry, patches)
- Excessive sweating
- Itching
- Dermatitis
- Flushing/ hot flashes
- Hair loss
- Dry skin

Emotions

- Aggressiveness
- Depression
- Mood swings
- Anxiety/fear
- Irritability/anger
- Nervousness

Mind

- Confusion
- Poor concentration
- Stuttering/stammering
- Learning disabilities
- Poor memory/brain fog
- Forgetfulness

Energy & Activity

- Apathy/fatigue
- Restlessness
- Hyperactivity
- Sluggishness

Other

- Chest pain
- General itching
- Urgent urination
- Frequent illness
- Irregular or rapid heartbeat
- Loss of taste or smell



Name: _____ DOB: _____ Date: _____

Male Patient Consult Form
Hormone Imbalance Checklist

1. Decline in your feeling of well-being (Episodes of Sweating)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
2. Joint and muscular Discomfort (Pain in the joints, Rheumatoid complaints)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
3. Excessive Sweating (Unexpected/sudden episodes of sweating, hot flashes)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
4. Sleep Problems (Difficulty in falling asleep, sleeping through, and waking up early)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
5. Depressive Mood (Feeling down, sad, lack of drive, tearful, mood swings)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
6. Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
7. Irritability (Feeling nervous, aggressive, inner tension)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
8. Anxiety (Inner restlessness, feeling panicky)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
9. Physical exhaustion/lacking vitality..... (Reduced activity, lacking interest in leisure activities)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
10. Bladder Problems (Hesitancy/retention of urine flow, decrease in urine stream)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
11. Sexual Problems (Decrease in ability/frequency to perform)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes
12. Decrease in beard growth	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Decrease in number of morning erections	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Decrease in muscular strength	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Decrease in sexual desire/libido	<input type="checkbox"/> Yes <input type="checkbox"/> No

For Office Use Only - Height: _____	Weight: _____	Weight Change: _____
Blood Pressure: _____	Pulse: _____	BMI: _____
Neck Circumference: _____	Waist Circumference: _____	
LMP: _____	Last MMG: _____	Last Pap: _____
Chief Complaint: _____		
What's Discussed: _____		

ALLERGY IMPACT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

1. Do you think you suffer from allergies? Yes No
2. Are the symptoms year – round or seasonal? Year round Seasonal
3. How long do your symptoms last during an allergy flare up? < than 7 days > than 7 days
4. What time of the day are your symptoms the worst? Morning Afternoon Night All day
5. Are the symptoms worse in the Spring, Fall or both? Spring Fall Both
6. Do you have any sinus drainage issues? Yes No If yes, when? AM PM All day
7. Do you ever have watery or itchy eyes? Always Most times Sometimes Never
8. Do you cough or sneeze on a regular basis? Yes No If yes, when? AM PM All day
9. Do you have regular upper respiratory infections? Yes No
If yes, when? 3 times or more a year Less than 3 times a year
10. Do you think you might be allergic to animals? Yes No
11. Have you ever been diagnosed with asthma? Yes No If yes, when? _____
12. Do you have a family history of asthma? Yes No
13. Have you ever been hospitalized for asthma? Yes No If yes, when? _____
14. How long have you lived in this area? _____ years / _____ months
15. How long have you lived in your current residence? _____ years / _____ months
16. Did you have allergies in your previous residence or state? Yes No
17. Are you currently taking any allergy medications? Yes No
If yes, please list them including OTC medications: _____

18. Are you currently taking blood thinner medications? Yes No
If yes, please list them: _____

19. Are you currently taking a beta blocker for a heart condition? Yes No Not Sure
20. Are you or could you be pregnant? Yes No



FINANCIAL POLICY

We are committed to providing you with the best possible care.

- We will provide you with the most appropriate care in the most time-efficient fashion.
- We will treat you with respect and professionalism
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may be times that we must reschedule your appointment with short notice.
- In order to give you as much notice as possible, we request a phone contact so that we can reach you in person during the day, such as a business number or cell phone.

If you have any questions regarding this information, please don't hesitate to ask us. We are here to help you.

General Information

- In order to treat you effectively and efficiently and within HIPPA guidelines, we require a registration form and several other forms be complete by you.
- We are sorry, but due to high fax volume we are NOT able to accept any of the following documents via fax. Without the completed documents, films, tests, and referral, if appropriate, you will NOT be seen by the doctor and your appointment will be RESCHEDULED.
 1. Referral, if required by your insurance
 2. Active valid insurance card
 3. Photo ID
 4. MRI films, and reports, CT scan films and reports, bone scan reports
 5. EMG reports
 6. Primary doctor's notes, other specialists' notes (orthopedic surgeon, neurologist, psychiatrist, rheumatologist, etc.)
 7. List of current medications

We expect that you have an understanding of your responsibilities under your insurance contract with respect to referral and preauthorization requirements, as well as your deductible, copay, coinsurance and coverage limits.

In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our Financial Policy.

If you have insurance coverage with one of the plans which we do participate with, we will bill your insurance company along the guidelines of our contract. However, we require that all co-pays are paid at the time of service.

If you have an insurance which we do not participate with, you will be provided with an Out of Network Contract.

Returned checks will be subject to an additional \$39 service fee.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize that your insurance is a contract between you, your employer and the insurance company. We are not a part to that contract.

While filing of insurance claims is a courtesy we extend to our patients, all charges are the responsibility of the patient from the date the services are rendered.

You will be required to show a copy of your insurance card at each time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered each visit until we are able to verify coverage.

If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you in receiving your maximum reimbursement.

Please help us serve you better by keeping your scheduled appointments.

There is a NO SHOW FEE for all appointments that are not cancelled within 48 hours of your appointment. Please be sure to get the staff members name, date and time that you spoke with them when cancelling an appointment.

I have read the Financial Policy. I understand and agree to this Financial Policy. I guarantee payment of all claims submitted to my insurance on my behalf. I further agree to pay any attorney fees, court costs and related collection agency fees incurred.

PATIENT NAME

PATIENT SIGNATURE

RESPONSIBLE PARTY SIGNATURE (If not patient)

DATE



AUTHORIZATION AND CONSENT

I request that payment of authorized Medicare Benefits be made on my behalf to **Renewus** for any services furnished to me by **Renewus**. I authorize any holder of medical information about me to be released to **Renewus** and its agents, this includes any information needed to determine these benefits or the benefits payable to related services. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

I request that payment of authorized Medigap Benefits be made on my behalf to **Renewus** for any services furnished me by **Renewus**. I authorize any holder of medical information about me to release to my insurance carrier any information needed to determine these benefits payable for related services.

AUTHORIZATION to release information and payment request. I certify that the service(s) covered by this claim has been received and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized agents any information needed for this or related claim.

ASSIGNMENT OF INSURANCE BENEFITS: I irrevocably assign all payments to **Renewus** for medical insurance benefits including any Major Medical Benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to **Renewus** for services performed during this period of treatment. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

RELEASE OF INFORMATION: **Renewus** may disclose any or all parts of the clinical record to me, my insurance company(s) or employer(s) for purposes of satisfying charges billed by **Renewus**. I further understand that it may be necessary for **Renewus** to contact my past or present employer(s) in regards to this claim. This authorization does not cover 3rd party liability claims.

GUARANTEE OF ACCOUNT: **Renewus**, for and in consideration of services rendered by **Renewus** to the below named patient, the undersigned (jointly and severally, if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills. There will also be a 35% collection fee and reasonable attorney fees, if your account goes to a collection agency.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

Patient's Name Patient Signature Date

Responsible Party Signature (if not patient)



Authorization to Discuss Medical Information

I, _____, hereby authorize you to use or discuss the specific information described below, only for the purpose and parties also described below.

Please select the specific information permitted to be discussed:

- Appointment dates/Time
- Medications
- Lab Test/Results
- Summary of Medical Records
- Care Plan
- Diagnosis

Patient Name: _____ D.O.B.: _____

Information permitted to be given to NAME(S)- _____

Relationship to patient: _____

Address: _____

Phone: _____

Multiple names may be added if you so choose

Thus authorization shall remain in effect from the date signed below until (please check one):

- Specific Date: _____
- NO EXPIRATION DATE

I understand that I may revoke this authorization by contacting your office, attention Administrator. This authorization is giving Renewus the right to discuss my medical information with the one or more people listed above. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA.

Patient Signature: _____ Date: _____



Authorization to Release Medical Records Outgoing

I hereby authorize:

Renewus
1400 Route 70 East 2nd floor
Cherry Hill NJ 08034
Phone: (888) 985-2727
Fax: (856) 375-2419

To release medical records and data pertaining to:

Patient Name:	SSN/MRN:
Date of Birth:	Phone Number:
Street Address:	City/State/Zip:

To the following physician/facility:

Physican/Facility: _____

Address: _____ City/State/Zip: _____

Phone/Fax: _____

Select the MOST RECENT records to be released:

- Labs: _____
- Radiology/Imaging: _____
- H&P/ Office Notes: _____
- Medication: _____
- Other: _____

Patient/Guardian Signature: _____ Date: _____