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 QUESTIONAIRE

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

☐ Belching/Bloating ☐ Bloated

☐ Abdominal Distention ☐ Cramps

☐ Gas (rectal) ☐ Constipation

☐ Diarrhea ☐ Nausea

☐ Stomach Pains ☐ Vomiting

☐ Lactose Intolerance ☐ Heartburn, acid reflux, indigestion

☐ Mucousy Stools

Head

☐ Dizziness ☐ Light Headedness

☐ Faintness ☐ Headaches

Mouth & Throat

☐ Chronic coughing ☐ Gagging

☐ Clear throat often ☐ Sore throat

☐ Swollen tongue, lips, or gums

Joint Muscles

☐ Muscle Aches ☐ Arthritis

☐ Feeling of weakness ☐ Limited movement

☐ Joint Pain ☐ Stiffness

Respiratory

☐ Asthma/ bronchitis- chronic ☐ Chest congestion

☐ Difficulty Breathing ☐ Shortness of breath resting or with mild exertion

☐ Wheezing ☐ Excessive mucous

☐ Hay fever ☐ Sinus problems

☐ Sneezing attacks ☐ Stuffy nose

☐ Nasal congestion ☐ Postal nasal drip

☐ Nasal polyps

☐ Sinus pressure or pain

Ears

☐ Ear aches ☐ Ear Infection

☐ Hearing Loss ☐ Itchy Ears

☐ Ringing in ears

Eyes

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

Weight

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

Skin

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

Emotions

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

Mind

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

Energy & Activity

☐ Apathy/fatigue
☐ Hyperactivity
☐ Restlessness
☐ Sluggishness

Other

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

Renewus™
WE PROMOTE HEALTHY FUTURES

Name:_____ DOB:_____ Date: _____

Female Patient Consult Form
Menopause/Hormone Imbalance Checklist

1. **Hot Flashes, sweating……** □ Yes □ No □ Sometimes
   (Episodes of Sweating)
2. **Heart Discomfort ……..** □ Yes □ No □ Sometimes
   (Unusual awareness of Heart Beat, Heart Skipping, Heart Racing, Tightness)
3. **Sleep Problems ……..** □ Yes □ No □ Sometimes
   (Difficulty in falling asleep, Difficulty in sleeping through, waking up early)
4. **Depressive Mood ……** □ Yes □ No □ Sometimes
   (Feeling down, Sad, Lack of drive, Tearful, Mood Swings)
5. **Irritability ……** □ Yes □ No □ Sometimes
   (Feeling nervous, Feeling aggressive, Inner tension)
6. **Anxiety ……** □ Yes □ No □ Sometimes
   (Inner restlessness, Feeling panicky)
7. **Physical and Mental Exhaustion ……..** □ Yes □ No □ Sometimes
   (Impaired memory, Decreased in concentration, Forgetfulness)
8. **Sexual Problems ……** □ Yes □ No □ Sometimes
   (Changes in sexual desire, Sexual activity, and Satisfaction)
9. **Bladder Problems ……..** □ Yes □ No □ Sometimes
   (Difficulty in urinating, Increased need to urinate, Bladder incontinence)
10. **Dryness of Vagina ……..** □ Yes □ No □ Sometimes
11. **Joint and Muscular Discomfort ……** □ Yes □ No □ Sometimes
    (Pain in the joints, Rheumatoid complaints)

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: _____

_____

Location: 1400 Route 70, 2nd floor, Cherry Hill NJ 08034 Phone: (888) 985- 2727

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 is 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: _____