Preventive Medicine
Anti-Aging and Chelation Therapy

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Los Angeles, CA 90048
P: 310-373-9303
F:310-928-7554

148 Cobb Parkway
Ringgold, GA 30736
P: 706-891-1200
F: 706-891-1202

5505 Peachtree Dunwoody
Rd. Suite 580
Atlanta, GA 30342
P: 678-705-2118
678-705-5767

Patient Registration Today's Date :_____

Patient Information

Patient Name: _____ DOB: ____/_____/_____
First MI Last

SSN#: _____ Marital Status: (__) M (__) S (__) D (__) W

Address: _____ City: _____

State: _____ Zip Code: _____ Ph#: _____

Mobile Ph: _____ Email: _____

Patient SHIPPING Information (Same as ABOVE? _____) NO P.O. Box for shipping!

Attention: _____ Ph#:_____

Address: _____ Suite: _____

City:_____ State: _____ Zip Code:_____

Patient Insurance Information

(___) Self-Pay : No Insuranc

Primary Insurance: _____ Policy#:_____

Please indicate the policyholder for the Primary Insurance. (__)Self (__)Spouse (__)Other_____

Secondary Insurance Information

(__) No Secondary Insurance Coverage

Secondary Insurance:_____ Policy#:_____

Please indicate the policyholder for the Primary Insurance. (__)Self (__)Spouse (__)Other_____

Emergency Contact Information

In case of an emergency, please list the nearest living relative/friend we may contact:

Name: _____ Relationship: _____

Phone #: _____ Mobile #:_____

Review of Systems

In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE ALL THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask a member of the office staff

Const. (Health in General) ❑No Problems; Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, memory loss, brain fog, fatigue. Other: _____

Eyes ❑No Problems; Visual changes, headache, eye pain, diplopia (double vision), tearing, scotomata (blind spots), floaters. Other: _____

Ears, Nose, Mouth & Throat ❑No Problems; Difficulty with hearing, ringing in ears, ear pain, vertigo, sinus problems, runny nose, post-nasal drip, nosebleeds, mouth sores, loose teeth, bleeding gums, sore throat, pain with swallowing, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑No Problems; Irregular heartbeat, chest pains, shortness of breath, swelling of feet or legs, high blood pressure, low blood pressure, pacemaker, heart attack, stroke. Other:_____

Resp. (Lungs & Breathing) ❑No Problems; Shortness of breath, chronic cough, wheezing, COPD, asthma, tuberculosis, oxygen at home, coughing up blood. Other: _____

GI (Stomach & Intestines) ❑No Problems; Heartburn, constipation, foods allergies, diarrhea, abdominal pain, nausea, vomiting, blood in stools, unexplained change in bowel habits, diabetes, low blood sugar.
Other:_____

GU (Kidney & Bladder) ❑No Problems; Painful urination, frequent urination, urgency, bladder problems, incontinence, renal failure. Other: _____

MS (Muscles, Bones, Joints) ❑No Problems; Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain, numbness. Other: _____

Integ. (Skin, Hair & Breast) ❑No Problems; Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑No Problems; Frequent headaches or migraines, double vision, weakness, change in sensation, vertigo, dizziness, tremor, loss of consciousness, seizures, episodes of visual loss.
Other:_____

Psychiatric (Mood & Thinking) ❑No Problems; Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑No Problems; Intolerance to heat or cold, frequent hunger/urination/thirst, changes in sex drive, thyroid trouble. Other: _____

Hematologic (Blood/Lymph) ❑No Problems; Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑No Problems; Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

For Women Only: (**GYN)** ❑No Problems; Irregular periods, heavy bleeding/clotting, abnormal vaginal discharge, pelvic pain, hysterectomy with or w/out removal of ovaries, night sweats, hot flashes, vaginal dryness, frequent cramping. Other: _____ Date of last menstrual: _____/_____/_____.

For Men Only: Decreased muscle mass/strength, atrophy, erectile dysfunction, decreased libido, history of prostate problems, history of elevated PSA.
Other:_____

Initial _____

Patient Name:_____ Today's Date:_____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint:_____
_____
When did this condition begin? _____/_____/_____ Did it begin: ☐ Gradually ☐ Suddenly
Does your complaint interfere with : ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine ☐ Explain_____
_____
Have you experienced this condition before? ☐ Yes ☐ No If YES, explain (when, duration, what made it better?)_____
_____
Who have you seen for this? _____What did they do?_____
How did you respond?_____
Who referred you to this practice?_____
Please list any other complaints:

1. _____
2. _____
3. _____
4. _____

WOMEN ONLY

First day of last menstrual period: ____/_____/_____
Are your cycles regular? ☐ Yes ☐ No – If no, how often? _____
How long do your cycles last? _____ days
Is your flow: ☐ Light ☐ Medium ☐ Heavy
Do you have pain or bleeding after sexual intercourse? ☐ Yes ☐ No
Have you ever been pregnant? ☐ Yes ☐ No – If Yes, how many children? _____
Date of last PAP smear: _____/_____/_____. Was it normal? ☐ Yes ☐ No
Date of last mammogram/breast exam: _____/_____/_____. Was it normal? ☐ Yes ☐ No
Do you perform monthly self-breast examinations? ☐ Yes ☐ No

MEN ONLY

Do you have an enlarged or infected prostate? ☐ Yes ☐ No
Pus or discharge from the penis? ☐ Yes ☐ No
Rupture or swelling in the groin? ☐ Yes ☐ No
Nodule in testicle which is growing larger? ☐ Yes ☐ No
Problem with sexual function (obtaining & maintaining errection)? ☐ Yes ☐ No
Pain or tenderness in the groin area? ☐ Yes ☐ No

Initial _____

Health Questionnaire

Do you have symptoms of chemical or heavy metal toxicity?

Patient Name:_____ Date: ____/_____/_____

(Put an 'x' by the ones that apply to you)

1.____ Do you have environmental and/or food allergies and sensitivities?
2.____ Are you prone to mood swings?
3.____ Do you have digestive problems and/or leaky gut syndrome (flatulence, change in bowel habits, constipation, diarrhea)?
4.____ Are you anxious and very irritable at times?
5.____ Do you suffer with irritable bowel syndrome (IBS), colitis, or Crohn's Disease?
6.____ Are you experiencing loss of memory and forgetfulness?
7.____ Do you have "brain fog"?
8.____ Do you have 'speech difficulties'?
9.____ Do you have high blood pressure (hypertension)?
10.___ Are you often extremely fatigued/tired (chronic fatigue)?
11.___ Do you now take or have you taken anti-depressants (depressed)?
12.___ Have you had a liver disease, and your liver is damaged?
13.___ Do you have unexplained headaches?
14.___ Do you have muscle tremors?
15.___ Is your sense of smell greater than most people?
16.___ Do you have an intolerance for alcoholic drinks?
17.___ Are you overly sensitive to tobacco smoke, perfumes, paint fumes and other chemical odors?
18.___ Have you found that there are many medications you can't take, and some vitamin and mineral supplements make you feel worse?
19.___ Have you discovered that you feel worse when shopping in certain stores, such as hardware stores, or in the cleaning section of grocery stores (where chemicals are)?
20.___ Are you allergic to many things?
21.___ Do you have a weakened immune system, catch colds frequently?
22.___ Do you have an autoimmune disorder?
23.___ Are you tired and sick a lot, no matter what remedies you try?
24.___ Do you have any silver fillings?
25.___ Do you have sore and/or receding gums?
26.___ Do you often have a metallic taste in your mouth?
27.___ Do you have sensitive teeth?
28.___ Do you smoke?
29.___ Do you have skin problems?
30.___ Do you often have chronic unexplained pain, especially in extremities?
31.___ Do you have severe chronic insomnia?
32.___ Have you found that you cannot lose weight, no matter how hard you try?
33.___ Do you take prescription and/or recreational drugs on a regular basis?
34.___ Have you developed neurological symptoms such as tingling in the extremities, muscle tics or twitches, or an unsteady gait?
35.___ Do you often have night sweats?
36.___ Do you have dark circles under the eyes?
37.___ Do you have low body temperature?
38.___ Are your hands and feet usually cold?
39.___ Do you have muscle and joint pain?
40.___ Do you have Fibromyalgia?
41.___ Are you prone to rashes that you cannot heal?
42.___ Are you now, or have you been exposed to toxic chemicals or metals either at home or in your workplace?
43.___ Do you work in agriculture, drug development, or in manufacturing?

Initial _____

Allergies

Please check all that apply & explain your reaction when exposed.

___Local Anesthetics
___Penicillin or other antibiotics
___Latex
___Codeine or other narcotics
___Aspirin
___Other: _____

Social History

Y=Yes, N=No, O=Occasionally

__Do you smoke? ____Packs per day.
__Do you chew tobacco? ____ amount per day
__Have you used recreational drugs in the past year, including prescription drugs not prescribed to you?
__Do you drink alcohol? ____drinks per week
__Do you have a history of alcohol abuse?
__Other: _____
_____

Do you consider yourself to be in good health? **Yes** **No** Height: _____ Current weight: _____

Are you currently under the care of a physician? **Yes** **No**
If so, who? _____
What condition(s) are they treating currently? _____

Have you ever been hospitalized? **Yes** **No**
If so please list the dates and reasons for Hospitalization: _____
_____
_____

Family History

__Cancer; Who: _____
__Diabetes; Who: _____
__Heart disease; Who: _____
__High Blood Pressure; Who: _____
__Thyroid Disorder; Who: _____
__Anesthetic Problems; Who: _____

I certify that I have read and understand the questions above. I acknowledge that I will have the opportunity to discuss my health history with my physician. I will not hold my physician or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Sign: _____ **Date:**_____

Consent to Antibody Testing, in the event of accidental exposure to blood or other bodily fluids through needle stick, cut, mucous membrane contact, or the like, the undersigned consents to appropriate tests for the presence of Hepatitis B & C and HIV, which is the virus believed to cause AIDS. The patient further agrees to hold harmless Preventive Medicine Anti-Aging Chelation, Inc., it entities and all employees should accidental exposure occur. The patient will be informed of any positive results, and all such results will be treated as confidential by Preventive Medicine Anti-Aging Chelation, Inc. There is no charge to the patient.

Sign: _____ **Date:** _____

PATIENT HEALTH HISTORY & QUESTIONNAIRE

Medications and/or Supplements you are currently taking

Name of Medication	Prescribing Physician	Dose of Medication	How many times a day do you take Medication	When did you start taking Medication	Why was Medication Prescribed

Patient Initial_____

CONSENT FOR TREATMENT

This **CONSENT FOR TREATMENT** is made and entered into this the _____ day of _____ 20___, by and between Preventive Medicine Anti-Aging Chelation, Inc. ("Physician") and _____("Client").

I hereby state that I have honestly and without exaggeration or omission, completed the attached "Patient Health History & Questionnaire". I also state that I have disclosed any and all information that might reasonably be considered relevant to decisions made by Physician regarding my care. I have disclosed **all past illnesses**, particularly those involving any form of cancer. I also state that I have disclosed all medications that I am taking at the present time and will inform Physician of any medications that may be prescribed now and in the future by other physicians. I also state that I have disclosed the past and present use of any substances including prescribed or nonprescription drugs, alcohol, steroids, vitamins, and dietary supplements. I hereby waive any claim or defense and hold harmless Preventive Medicine Anti-Aging Chelation, Inc. ("Physician") for any harm or injury I sustain as a result of my failure to fully disclose all relevant facts about my physical and medical condition to Physician. I hereby waive any claim or defense and hold harmless Preventive Medicine Anti-Aging Chelation, Inc. ("Physician") for any harm or injury I sustain as a result of my failure to fully comply with the method of treatment and dosage schedule prescribed by Physician. I agree to immediately cease any medical treatment prescribed by Physician in the event of any adverse response or side effect arising from prescribed treatment and to provide immediate written notice of such adverse response or side effect(s) to Physician via fax to (706) 891-1202. I agree to comply with the prescribed instructions for use of all medications prescribed by Physician. I agree all medications are for my personal use and are not to be used by anyone other than myself.

I understand that the practice of medicine is not an exact science and that all diagnosis and treatment may involve risks of injury, including but not limited to permanent injury and death. I acknowledge that no guarantees have been made to me as to the result of diagnostic testing analysis of test results, examination of medical history, or treatment by Physician.

I am or have been made aware to my satisfaction of the nature, risk, possible alternative methods of treatment, possible consequences, and possible complications involved in a course or treatment utilizing hormone replacement therapy. I am also aware that some studies exist that show a possible connection between replacement therapy and cancer. I am also aware that in the event that I develop some form of cancer, hormones that I am taking may make cancer worse. Replacement of hormones may, in some cases, cause a decrease in the body's natural ability to produce those hormones. Protocols are designed to limit that possibility, but that facts do not constitute hormone replacement therapy and, if accepted, that I be given hormone replacements.

I have read and understand the forgoing **CONSENT FOR TREATMENT** and have signed the same as by voluntary act and deed.

Please Print Name:_____ **Date:**_____

Please Sign Name:_____ **Date:**_____

HIPAA – ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Date of Birth: _____

We at Preventive Medicine Anti-Aging & Chelation are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.
I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patient's representative/parent Date

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Relationship to patient

Therapy Consent Form

I _____ hereby acknowledge that I have the right as a patient to either accept or decline any therapies recommended to me by the health care providers of Preventive Medicine Anti-Aging and Chelation Therapy, and the decisions to accept or decline therapies is at my own free will. In the case that I receive a prescription I acknowledge that I have the option to have my prescription called in, faxed, or have a hand written prescription.

Signature:_____ Date:_____

Print Name:_____

Guardian Signature (If Applicable) :_____ Date:_____

Print Name:_____

Relationship to patient:_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Preventive Medicine Anti-Aging and Chelation Therapy, Robert A. Burkich MD, Jimmy Diaz MD, Misty Branam FNP, Angel Nofziger FNP, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____
(patient signature)

_____
(please print patient name)

X_____
(signature of Guardian if applicable)

Notification Policy

We are now offering a reminder service to better help you remember your appointment date and time. If you would like to utilize these services please select how you would like to be reminded and sign below.

Phone Call: _____Text Message:_____ E-Mail:_____

***Text message rates may apply depending on your phone carrier and contract**

Cancellation Policy

In order to serve our patients better, we have instituted a cancellation policy. If you cannot make it to your appointment please contact us 24 hours in advance to cancel your appointment. **If you DO NOT cancel 24 hours in advance you will be charged a no-show fee of $50.00.**

Insurance Consent

Insurance is considered a method of reimbursing you "the patient" for fees paid to the doctor **and is not a substitute for payment.** Some companies pay a fixed allowance for certain procedures and others pay a percentage of the services charged. Please remember: **It is your responsibility to pay any deductible amount, co-pays, and any other balance not paid by your insurance company. Initial: _____**

If this account is assigned to an attorney for suit and/or turned over to collections, I understand that I will be fully and wholly responsible for all attorney fees, court costs and the full costs of collections incurred, by what is herein referred to as the practice (and its entities). **Initial: _____**

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my, herein referred to as the patients records. **Initial: _____**

Insurance Authorization and Assignment

I hereby authorize Preventive Medicine Anti-Aging and Chelation Therapy (and its entities) to furnish information to the insurance carriers, and I hereby assign to all physicians all payment for medical services. **I understand that I am responsible for any and all no/non covered fees.**

Payment Authorization

It is a courtesy for our office to file your insurance; however you are responsible before seeing your physician to provide your co-pay, deductible and/or percentage, which the insurance company will not pay. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor your account will be given to our collection agency and you will be responsible for additional collections (*i.e.,* interest and attorney's expenses incurred) if applicable.

*I, _____, have fully read and understand the above statement of payment policy. I also state that all of the above information is the most current and updated information.

***Patient's Signature** _____ **Date** _____/_____/_____