PATIENT REGISTRATION FORM

Please Print and Fill Out Completely

Patient Last Name_____ First_____ Middle Initial ____

Address_____City_____ State_____ Zip_____

Home Phone #_____ Cell Phone #_____ Other Phone #_____

Social Security #_____ Date of Birth_____ Age_____ Sex: M or F Marital Status_____

Do you consider yourself to be: ☐White ☐Hispanic/Latino ☐Black/African American ☐Asian

☐American Indian ☐Native Hawaiian/Other Pacific Islander ☐Other_____

☐I do not wish to disclose this information

Employer _____ Address _____ Phone _____

Emergency Contact _____ Phone # _____ Relationship_____

Primary Physician _____ Phone #_____

Referring Physician _____ Phone #_____

Is this a work or auto related injury? YES or NO **Claim #**_____ **Date of Injury**_____

- I hereby authorize Physicians and Providers Robert J Bess, and or, Jack B Rentz to treat the Patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance will not pay for all chargers and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

- Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for any fees or non-covered services. I also authorize the physician to release my information required in the processing of this claim and all future claims.

Signature of Patient/Authorized Person_____ Date _____

CONTACT DISCLOSURE FORM

Patient Name: _____ DOB:_____

Contact Phone Number:

Home:_____ Cell:_____

OK to leave a detailed message regarding scheduling on voice mail?

_____ YES

_____ NO

Work Phone Number: _____

OK to leave a detailed message regarding scheduling on voice mail?

_____ YES

_____ NO

Email Address: _____

Person(s) we can discuss scheduling and/or billing information or leave messages with regarding your appointment:

_____ Spouse, Name:_____

_____ Children, Name(s):_____

_____

_____ Other, please specify by name:_____

OFFICE POLICIES

REFERRALS:
Referrals to specialists will be handled on the same day for urgent matters and within 72 hours for all other appointments. Please make sure our office staff has the best phone number to reach you in order to communicate your appointment information. We will make every effort to insure that the specialist accepts your insurance. However, **it is ultimately each individual patients responsibility to confirm that a specialist is covered by your specific insurance plan prior to your appointment.**

AFTER HOURS PROCEDURES:
During times that the office is closed, phone calls to the main office number will be forwarded to our answering service. The on-call physician will be paged for calls requiring immediate attention. All other calls will be directed to our office during regular office hours.

After-hours calls to the physician may be indicated to address concerns about an acute illness or new symptom, or worsening symptoms of an existing illness. **All life-threatening symptoms should be directed to 911 emergency response.**

Per policy, refills and prescriptions for narcotic pain medications will not be done after-hours.

BILLING:
All fees charged for regenerative medical procedures are due and paid directly after the procedure. We accept cash, check and most major credit cards.

APPOINTMENTS
Patients are seen at the Colorado Stem Cell Center by appointment **only**. Please call our office for an appointment.

Please arrive **20 minutes prior** to your scheduled appointment for all new patient appointments and **5 minutes prior** to all return visits. There are numerous forms which need to be completed (if not done so previously) at the first visit. Routine forms also need to be updated at least annually.

CANCELLATION/NO-SHOW POLICY:

We respectfully request that you cancel appointments with a 24-hour notice, if possible. We appreciate early notification of your change of plans so that we may offer that appointment for another date/time. We strive to maintain a relationship with you where we will value each other's time. However, if there is a "no-show" and "no-call", the patient will be charged a "no-show" fee of $100.00.

HISTORY AND PHYSICAL

Patient Name:_____ DOB:_____

Past Medical History:

- Medical Problems:

- Surgeries:

Medications & Dosages:

Allergies:

Social History:

- Occupation:
- Alcohol:
- Tobacco:
- Recreational Drugs:

REVIEW OF SYSTEMS

Please if you are or have been experiencing any of the symptoms listed below

GENERAL

_____ Fever
_____ Chills
_____ Night Sweats
_____ Unexplained weight loss

HEAD, EAR, EYE, NOSE, THROAT

_____ Visual
_____ Hearing loss
_____ Sore throat

SKIN

_____ Skin changes

CARDIAC

_____ Chest pain
_____ Heart attack
_____ Palpitations
_____ Congestive heart failure

RESPIRATORY

_____ Shortness of breath
_____ Wheezing
_____ Cough
_____ Sleep Apnea

PSYCHIATRIC

_____ Psychiatric history

GASTROINTESTIONAL

_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Abdominal pain
_____ Bloody stools

HEMATOLOGIC

_____ Bleeding problems
_____ Easy bruising
_____ Anemia
_____ HIV
_____ Hepatitis

ENDOCRINE

_____ Thyroid problems

_____ Diabetes

GEITOURINARY

_____ Frequent urination
_____ Burning with urination
_____ Prostate problems
_____ Kidney disease