

VERMONT
REGENERATIVE MEDICINE



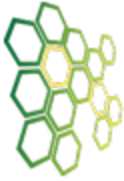
Hello, and welcome to the world of regenerative orthopedic medicine! If you have found your way to this form, you are interested in what regenerative orthopedic medicine can do to help with your specific musculoskeletal condition(s). If you would like to establish yourself as a patient with our practice, please fill out the following form and submit it to us prior to your appointment.

As part of our commitment to provide you with extraordinary care, your new patient appointment will include an in-depth physical, a dynamic musculoskeletal ultrasound exam, and a review of your past imaging. X-ray and MRI images are both useful – they will need to be two years old or newer to provide us with the most accurate information. It is recommended that your images be copied on a compact disc; you may send them ahead of time or bring them with you on the day of your evaluation appointment.

To learn more about the procedures we offer, view the most up to date outcome data, or listen to patient testimonials please visit the [Regenexx website](#).

We look forward to providing you with the best regenerative orthopedic care that is currently available.

- Jonathan Fenton, D.O.



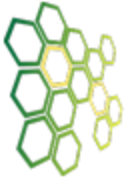
New Patient Intake Form

Basic Patient Information

Name:		Phone number:	
Mailing Address:			
Email Address:			
Date of Birth:		Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Ethnicity:	<input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic	Race:	
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Occupation:		Employer:	
Education level:			
Emergency Contact:		Phone number:	
Primary Doctor:		May we send them a report?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Referring Doctor:		May we send them a report?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Motor vehicle or workplace injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Date of injury:	
Briefly describe how your problem(s) began:			

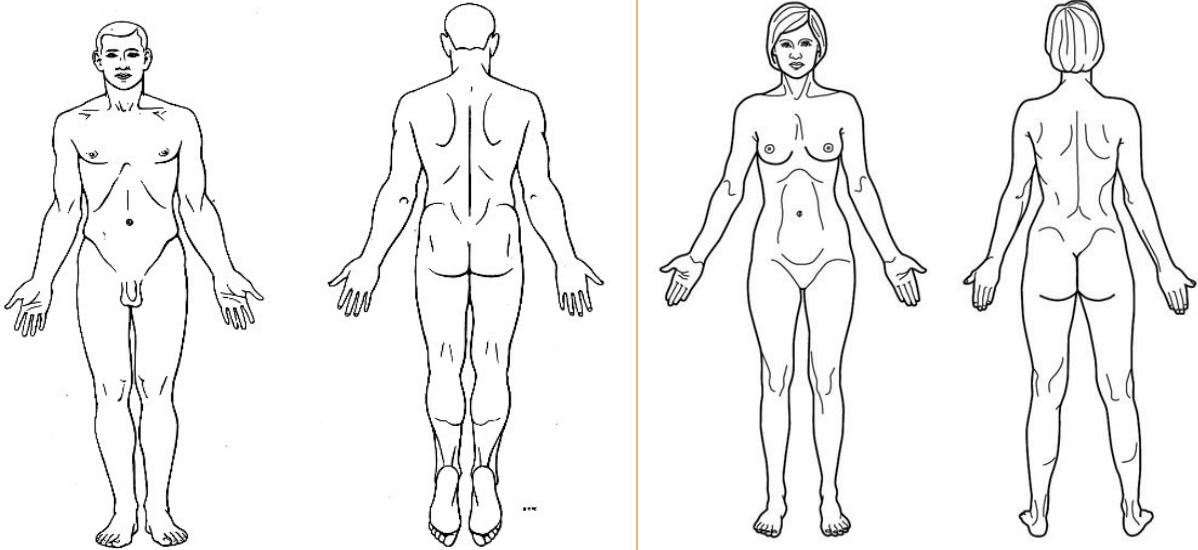


<p>Current medications: ex. Aspirin 81mg 1x/daily (please include non-prescription medicines and supplements)</p>	
<p>Allergies: Please list the drug/substance name(s) with type and severity of your reaction(s)</p>	
<p>Do you currently use/consume?</p>	<p>Tobacco or Tobacco products: <input type="checkbox"/> No <input type="checkbox"/> Yes Marijuana: <input type="checkbox"/> No <input type="checkbox"/> Yes, how often: Alcohol: <input type="checkbox"/> No <input type="checkbox"/> Yes, how many drinks per week:</p>
<p>What do you do for exercise? How long? How often?</p>	
<p>List any past surgeries and the year performed:</p>	



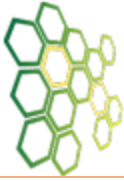
Location of Present Pain/Dysfunction

Please indicate where you suffer from pain or dysfunction and list from most to least severe. Be specific! ex. Inside of my right knee. Hint: use the highlighter function if filling out electronically

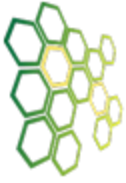


1:	
2:	
3:	
4:	
5:	

Severity of pain:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
From 0 (No pain) to 10 (Agonizing):	At best ___/10 At worst ___/10 Now ___/10
Quality:	<input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Sharp <input type="checkbox"/> Cramping <input type="checkbox"/> Spasming <input type="checkbox"/> Numbing <input type="checkbox"/> Electric shock
Frequency:	<input type="checkbox"/> Intermittent <input type="checkbox"/> Continuous <input type="checkbox"/> Waxes and wanes
Does your pain Radiate:	<input type="checkbox"/> No <input type="checkbox"/> Yes, where?



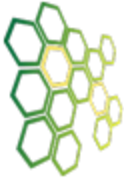
What makes your pain worse?	Back and Legs: <input type="checkbox"/> Lifting <input type="checkbox"/> Twisting <input type="checkbox"/> Weight bearing <input type="checkbox"/> Prolonged sitting <input type="checkbox"/> Prolonged standing <input type="checkbox"/> Walking <input type="checkbox"/> Uneven terrain <input type="checkbox"/> Other: Neck and Arms: <input type="checkbox"/> Lifting <input type="checkbox"/> reaching overhead <input type="checkbox"/> reaching behind back <input type="checkbox"/> looking up/down <input type="checkbox"/> Other:
What makes your pain better?	<input type="checkbox"/> Nothing <input type="checkbox"/> Rest <input type="checkbox"/> Ice <input type="checkbox"/> Heat <input type="checkbox"/> Stretching <input type="checkbox"/> Walking <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Frequent positional changes <input type="checkbox"/> Tylenol <input type="checkbox"/> Ibuprofen <input type="checkbox"/> naproxen <input type="checkbox"/> Muscle relaxant medication <input type="checkbox"/> Pain medications <input type="checkbox"/> Exercise <input type="checkbox"/> Physical therapy <input type="checkbox"/> Chiropractic <input type="checkbox"/> Massage <input type="checkbox"/> Other:
Treatments attempted:	<input type="checkbox"/> Nothing <input type="checkbox"/> Ice or Heat <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Steroid injections <input type="checkbox"/> NSAIDs (Ibuprofen, Aleve, Naproxen) and how often? Other treatments:
Do you have weakness?	<input type="checkbox"/> No <input type="checkbox"/> Yes, where?
Tingling, numbness, or decreased sensation?	<input type="checkbox"/> No <input type="checkbox"/> Yes, where?
Do you limp when you walk?	No <input type="checkbox"/> Yes <input type="checkbox"/>



Personal Medical History

Please indicate if you suffer from any of the following conditions:

Alcoholism	<input type="checkbox"/>	Migraines	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	History of fainting	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	Lyme disease	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Other chronic infection	Type: <input type="checkbox"/>
Low platelet count	<input type="checkbox"/>	Gout	<input type="checkbox"/>
Other bleeding disorder	Type: <input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	Psoriatic arthritis	<input type="checkbox"/>
Cancer	Type: <input type="checkbox"/>	Reactive arthritis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Other autoimmune condition	Type: <input type="checkbox"/>
COPD	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Ankylosing spondylitis	<input type="checkbox"/>
Drug abuse	<input type="checkbox"/>	DISH	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	Low thyroid	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	Low testosterone	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	Low estrogen	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Other endocrine condition	Type: <input type="checkbox"/>
Generalized joint hypermobility	<input type="checkbox"/>	Ethlors-Danlos Syndrome	<input type="checkbox"/>



Review of Systems

Are you currently experiencing any of these symptoms?

Constitutional symptoms:	<input type="checkbox"/> Fever <input type="checkbox"/> weight loss <input type="checkbox"/> weight gain <input type="checkbox"/> extreme fatigue
Eyes:	<input type="checkbox"/> Double vision <input type="checkbox"/> blurry vision <input type="checkbox"/> intolerance to bright light
Ears:	<input type="checkbox"/> Hearing loss <input type="checkbox"/> tinnitus (ringing) <input type="checkbox"/> discharge
Nose:	<input type="checkbox"/> Bleeding <input type="checkbox"/> discharge <input type="checkbox"/> congestion <input type="checkbox"/> post-nasal drip
Mouth:	<input type="checkbox"/> Dental problems <input type="checkbox"/> bleeding gums <input type="checkbox"/> TMJ pain
Cardiovascular:	<input type="checkbox"/> Chest pain <input type="checkbox"/> palpitations or irregular heartbeat
Respiratory:	<input type="checkbox"/> Cough <input type="checkbox"/> wheezing <input type="checkbox"/> shortness of breath <input type="checkbox"/> trouble taking a deep breath
Gastrointestinal:	<input type="checkbox"/> Nausea <input type="checkbox"/> vomiting <input type="checkbox"/> abdominal pain <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> blood in stools <input type="checkbox"/> loss of appetite <input type="checkbox"/> heartburn (GERD)
Musculoskeletal:	<input type="checkbox"/> Other pains not listed, location:
Skin:	<input type="checkbox"/> Rash <input type="checkbox"/> itching <input type="checkbox"/> abnormal sweating
Genitourinary:	<input type="checkbox"/> Irregular periods <input type="checkbox"/> vaginal bleeding after menopause <input type="checkbox"/> frequent or painful urination <input type="checkbox"/> bloody urine <input type="checkbox"/> impotence <input type="checkbox"/> pain with sex
Neurological:	<input type="checkbox"/> Headache <input type="checkbox"/> sleep complaints <input type="checkbox"/> tingling or numbness <input type="checkbox"/> weakness
Psychiatric:	<input type="checkbox"/> Depression <input type="checkbox"/> anxiety <input type="checkbox"/> suicidal thoughts <input type="checkbox"/> little interest or pleasure in doing things
Endocrine:	<input type="checkbox"/> Excessive thirst <input type="checkbox"/> cold or heat intolerance <input type="checkbox"/> excessive urination or appetite <input type="checkbox"/> hair loss <input type="checkbox"/> very dry skin <input type="checkbox"/> leg/feet swelling
Hematologic:	<input type="checkbox"/> Unusual bruising or bleeding <input type="checkbox"/> enlarged lymph nodes <input type="checkbox"/> edema



Family History

Please indicate any individual in your immediate family who suffers from the following:

- | | | | |
|-----------------------------------|-----------------------------|------------------------------|------|
| Similar problems to yours? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |
| Disability | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |
| Arthritis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |
| Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |
| Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |
| Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |
| Auto Immune disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |
| Thyroid disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |
| Elevated cholesterol | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |
| Hypertension | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |
| Other: | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? |



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Financial Policy

Name: _____

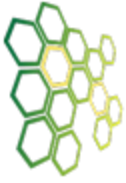
You, the patient, are responsible for your medical bills. If you are covered by an insurance which Vermont Regenerative Medicine bills, we will submit the forms for you and bill you for any remaining balance. If you have an insurance that we do not bill, we will give you a form which you can submit yourself. Not all insurances cover office visits and currently no regenerative medicine treatment is covered by any insurance. If you elect to proceed with a regenerative medicine procedure, you will be required to pay the full price on the day of the procedure.

Co-pays and dispensary purchases are due at the time of service.

I have read, understood, and agree to the Financial Policy. I authorize the release of any information necessary to process my claims. I also give permission for your office to leave a message on my phone.

Signature: _____

Date: _____



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HIPAA Acknowledgement

Name of Patient: _____ Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of Vermont Regenerative Medicine's Notice of Privacy Practices

Signature of Patient/Patient Representative

Date

Relationship to Patient