Date:

NEW PATIENT INTAKE FORM A

GENERAL INFORMATION

First Name: Middle: Last:

Preferred Name: Date of Birth: Gender: Male Female

Current Height (ft/inches): Current Weight:

Longest Weight Fluctuations:

Background: African European Native American Mediterranean

Asian Ashkenazi Middle Eastern Other

PRIMARY/SHIPPING ADDRESS (Person completing this form)

Address: Apt #:

City: State: Zip:

Cell Phone: Home Phone:

Work Phone: Email:

Fax:

BILLING ADDRESS (Where you receive your credit card statements)

Address: Apt #:

City: State: Zip:

EMERGENCY CONTACT

Name: Phone:

Address: Apt #:

City: State: Zip:

Date:

REFERRED BY Website ☐ Media ☐ Friend or Family member ☐

Patient Coordinator:

CONCERNS

What do you hope to achieve in your visit with us?

When was the last time you felt well?

Did something trigger your change in health?

Is there anything that makes you feel worse?

Is there anything that makes you feel better?

Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

Describe problem	mild	moderate	severe	Prior Treatment/Approach	excellent	good	fail
	○	○	○		○	○	○
	○	○	○		○	○	○
	○	○	○		○	○	○

DENTAL HISTORY

Fillings How many?

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ○ Yes ○ No

MEDICAL HISTORY Diseases/Diagnosis/Conditions

Check appropriate box and provide date of onset.

Date:

P = Past C = Current F = Family If the answer is NONE, please leave blank.

P	C	F	GASTROINTESTINAL	Date of Onset
			Irritable Bowel Syndrome	
			Inflammatory Bowel Disease	
			Crohn's	
			Ulcerative Colitis	
			Gastritis / Peptic Ulcer Disease	
			GERD (reflux)	
			Celiac Disease	
			Other	

P	C	F	CARDIOVASCULAR	Date of Onset
			Heart Disease	
			Elevated Cholesterol	
			Hypertension (high blood pressure)	
			Rheumatic Fever	
			Mitral Valve Prolapse	
			Other	

P	C	F	METABOLIC/ENDOCRINE	Date of Onset
			Type 1 Diabetes	
			Type 2 Diabetes	
			Hypoglycemia	
			Metabolic Syndrome (Insulin Resistance or Pre-Diabetes)	
			Hypothyroidism (low thyroid)	
			Hyperthyroidism (overactive thyroid)	
			Endocrine Problems	
			Polycystic Ovarian Syndrome (PCOS)	
			Weight Gain	
			Weight Loss	
			Frequent Weight Fluctuations	
			Bulimia	
			Anorexia	
			Binge Eating Disorder	
			Night Eating Syndrome	
			Eating Disorder (non-specific)	
			Other	

P	C	F	INFLAMMATORY/AUTOIMMUNE	Date of Onset
			Chronic Fatigue Syndrome	
			Autoimmune Disease	
			Rheumatoid Arthritis	
			Lupus SLE	
			Immune Deficiency Disease	
			Severe Infectious Disease	
			Poor Immune Function (frequent infections)	
			Food Allergies	
			Environmental Allergies	
			Multiple Chemical Sensitivity	
			Latex Allergy	
			Other	

P = Past C = Current F = Family

Date:

If the answer is NONE, please leave blank.

P	C	F	GENITAL/URINARY SYSTEMS	Date of Onset
			Kidney Stones	
			Urinary Tract Infections	
			Yeast Infections	
			Other	

P	C	F	MUSCULOSKELETAL/PAIN	Date of Onset
			Arthritis	
			Fibromyalgia	
			Chronic Pain	
			Other	

P	C	F	CANCER	Date of Onset

P	C	F	RESPIRATORY DISEASES	Date of Onset
			Frequent Ear Infections	
			Frequent Upper Respiratory Infections	
			Asthma	
			Chronic Sinusitis	
			Bronchitis	
			Sleep Apnea	
			Other	

P	C	F	SKIN DISEASES	Date of Onset
			Eczema	
			Psoriasis	
			Acne	
			Other	

ALLERGIES

☐ None

P = Past C = Current F = Family

Date:

If the answer is NONE, please leave blank.

P	C	F	NEUROLOGIC/MOOD	Date of Onset
			Depression	
			Anxiety	
			Bipolar Disorder	
			Schizophrenia	
			Headaches	
			Migraines	
			ADD/ADHD	
			Sensory Integrative Disorder	
			Autism	
			Mild Cognitive Impairment	
			Multiple Sclerosis	
			ALS	
			Seizures	
			Other	

P	C	F	INJURIES	Date of Onset
			Back injury	
			Neck Injury	
			Head Injury	
			Broken Bones	
			Other	

P	C	F	PREVIOUS EVALUATIONS	Date
			Full Physical Exam	
			Psychological Evaluations	
			Wechsler Preschool & Primary Scale of Intelligence	
			Speech & Language Evaluations	
			Genetic Evaluation	
			Neurological Evaluations	
			Gastroenterology Evaluations	
			Celiac/Gluten testing	
			Allergy Evaluation	
			Nutritional Evaluation	
			Auditory Evaluation	
			Vision Evaluation	
			Osteopathic	
			Acupuncture	
			Physical Therapy	
			Occupational Therapy	
			Sensory Integration Therapy	
			Language Classes	
			Sign Language	
			Homeopathic	
			Naturopathic	
			Craniosacral	
			Chiropractic	
			MRI	
			CT Scan	
			Upper Endoscopy	
			Upper GI Series	
			Ultrasound	
			Other	

Date:

	MEDICATION	DOSAGE/ TYPE/ SIZE /STRENGTH	START DATE	DETAILS / CHANGES IN DOSAGES
	Anastroze capsules	mg		
	Omnitrope mg vial	mg		
	Testosterone cypionate / zinc	00mg/ml-mg 0ml		
	Mic, B-Complex w/Lidocaine	/0/0, mg Lido 0ml		
	B-Complex	00mg/ml 0mg		
	HCG	How many? IU		
	Sermorelin	mg/mg/mg		
	Testosterone gel	How many times a day?		
	Testosterone cream	How many times a day?		
	L-Carntine	0mg/ml - 0ml		
	Armour thyroid tablet			
	L-Arginine			
	Lipitor			
	Crestor			
	Other			

Date:

1. Informed Consent Regarding Nutritional Supplements
2. Patient Consent
3. Consent to Treatment
4. Insurance and HRT
5. Authorization to Release Healthcare Information

1. Informed Consent Regarding Nutritional Supplements

You Are Under No Obligation To Purchase Nutritional Supplements Through This Office.

As a service to you, we make nutritional supplements available in our office.

We provide these products only from manufactures who have gained our confidence through considerable research and experience.

We determine quality by considering:

the quality of science behind the product;

the quality of the ingredients themselves;

the quality of the manufacturing process; and the synergism among product components.

The brands of supplements that Regenx offers meet our high standards and tend to produce predictable results. We only use nutritional supplements that have achieved triple GMP Good Manufacturing Practices certification from leading independent quality organizations.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, effectiveness, quality, bioavailability facility to be properly absorbed and utilized by the body as well as the absence of toxins. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely. According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 0 g, the term drug is defined as an " article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, or amino acids are not classified as drugs.

However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biochemical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications drugs, but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements you may be taking. If you have any questions regarding Nutritional Supplements, please discuss them with our staff.

Date:

2. Patient Consent

Use & Disclosure of Confidential Health Information

I, understand that as part of my health care, RegenX Medical Institute staff originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment. A means of communication among the many health professionals who may contribute to my care; A source of information for applying my diagnosis to my bill. I understand and I have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent The right to object to the use of my health information for directory purposes. The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand that RegenX Medical Institute is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by the Code of Federal Regulations. I further understand that RegenX Medical Institute reserves the right to change their notice and practices and prior to implementation, in accordance with the Code of Federal Regulations. If RegenX Medical Institute changes its privacy notices, we will issue a revised notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information RegenX Medical Institute maintains. I understand that I may obtain a copy of RegenX Medical Institute Notice of Privacy Practices, including revisions of Notice, at any time by contacting RegenX Medical Institute at: 1060 Kane Concourse, Bay Harbor Florida, 33154 , or calling 305.973.4369.

I have had full opportunity to read and consider the contents of this Consent form and RegenX Medical Institute Notice of Privacy Practices. I understand that as part of treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these uses as permitted by law.

3. Consent to Treatment

I hereby give my consent to evaluation and treatment of Andropause, thyroid disorders, adrenal fatigue/stress, menopause and other hormone imbalances by providing a prescription of Hormone Replacement Therapy "HRT" and/or nutritional supplements, including vitamins, minerals and anti-oxidants and/or bio-identical supplements designed to alter hormone levels. The nature of the procedure is to raise levels of hormone in my body to levels which will improve quality of life, as well as functional ability, the goal of which being to decrease the incidence of sickness and disease.

I.) Alternative Treatment Approach

The reasonable alternatives to these therapies have been EXPLAINED to me and they include,

but are not limited to:

- MAINTAINING CURRENT HORMONE LEVELS
- TREATING CHRONIC PERSISTENT DISEASES AS THEY OCCUR
- TREATING SYMPTOMS WITH BIO-IDENTICAL MEDICATIONS

Date:

II.) The General Nature and Extent of Treatment-Related Risks

Most hormone deficiencies are indicated by symptoms and may implicate the potential for illness when certain hormone levels are too high or low. Along with my doctor, I believe that it is when hormones are within a safe range to reduce my unwanted symptoms, that we will obtain the optimum goal in my health.

In Andropause, men gradually lose their ability to produce testosterone and some men develop elevated levels of estrogen. As men undergo an ever-increasing loss of testosterone, they are faced with anxiety, irritability, erectile dysfunction, bone loss, muscle loss, loss of strength, and loss of energy and memory impairment.

Possible side effects of male testosterone replacement or improper use include, but are not limited to: unwanted hair growth, enlargement of the prostate, loss of sperm production sterility, enlargement of breast tissue, testicular atrophy shrinking, acne, oily skin and hair, and in some studies, an increased risk of prostate cancer growth.

With respect to adrenal function, my doctor has explained the risks of adrenal therapy with me including the long term use of corticosteroid cortisol which has been associated with osteoporosis. I understand that my doctor will use other methods to help reestablish my own adrenal hormone production, but that this may involve the short term use of cortisol. In addition, I will be informed of long term complications if my doctor and I feel that long term use of cortisol is indicated.

In hypothyroidism, studies have shown that physicians may under-treat this condition. I understand that my physician will be working with me to suppress my symptoms and improve my quality of life by considering my symptoms, as well as my thyroid hormone levels to monitor the treatment of my disease. I understand that the potential side effects in using thyroid medication including osteoporosis, palpitations, dizziness, psychiatric problems mania, and elevated or irregular heart rate.

With respect to age and the incidence of Adult Growth Hormone Deficiency Syndrome: I appreciate that there are certain risks associated with the use of human growth hormone, or growth hormone secretagogues.

While growth hormone has been shown to increase muscle mass, lower fat mass and improve bone density, the clinical guidelines for the diagnosis and treatment of such a hormone loss have yet to be clearly established. Therefore, my physician at Regenx and I have discussed the benefits of human growth hormone and the associated risks. These risks include: water retention, which may result in leg swelling and elevated blood pressure, mild increase in fasting blood sugar and occasional bruises at the injection site. I may also develop infection at the injection site if I use improper technique. Most all of these side effects are reversible by dosage adjustment or discontinuing therapy. I understand that there are reasons to avoid the use of human growth hormone if I am prescribed such a medication. Some of these reasons are as follows: pre-existing cancer or tumors; uncontrolled diabetes; unusual lung diseases such as pulmonary fibrosis; pneumoconiosis; proliferative disease; bronchiolitis obliterans; systemic sclerosis or pregnancy. I do not currently have nor have I been diagnosed with any of these medical problems. I understand that if I am diagnosed with any of these medical problems, I should stop the entire treatment protocol immediately and notify my physician, so that my treatment plan can be reevaluated. I understand that taking growth hormone raises IGF- levels in the blood. In addition to the risks discussed above, I am aware that there are reports that indicate there may be an increased risk of prostate cancer associated with higher IGF- levels.

In menopause, women lose the majority of their hormones within a few years, causing in many cases, severe

distress, both mental and physical. Through the use of hormone replacement therapy, one can counter this decline and help alleviate the symptoms due to menopause. Additionally, studies now indicate that hormone therapy is effective in the treatment of osteoporosis, as well as other disease process associated with hormone decline as we age. The potential adverse effects for women using estrogen, progesterone and/or testosterone include, but are not limited to: breast swelling and/or discomfort, fluid retention, dizziness, palpitations, break through bleeding, requiring an endometrial biopsy, acne, unwanted hair growth, oily skin and hair, and headache.

I also understand that if I am female and become pregnant, I should discontinue the entire treatment protocol immediately and notify my physician.

I understand that this hormone therapy is not for the purpose of preventing pregnancy.

If I should become pregnant during the course of therapy, there are potential risks to the fetus unborn.

III.) Safety of Hormone Replacement

Although in my physician's opinion, the majority of data points toward safety, no one has yet proven or has yet disproven a causal relationship between the use of hormone therapy and cancer. I understand that careful surveillance and close monitoring are requirements of all patients to minimize any possible risk. I understand there are other studies that point to a higher incidence of cancer in patients who take Hormone Replacement Therapy. However, these studies, which show an association two variables present simultaneously, do not demonstrate cause and effect. I realize that it may be a number of years before we know if there is any true cause and effect between hormones and increased risk for cancer in women or men. I understand that although each hormone has been approved by the Food and Drug Administration "FDA" for use in the treatment of certain diseases, I also understand that the FDA only approves or disapproves of products made by manufacturers which are produced in an established dosage and form. Therefore by definition, the FDA does not "approve" or "disapprove" of hormones which are given in an individual dose and in an appropriate form for each patient as determined by my doctor at Regenx. I also understand that my doctor may choose to discuss with me and provide to me medications that are off-label in order to offer to me the widest range of therapies possible. "Off-label" use means the use of FDA approved drugs for purposes other than those for which the FDA has approved them. "Off-label" prescribing is a legal and common practice by physicians in the United States. A recent study found that more than 0% of overall prescription drugs in the U.S. and close to 0% of drugs in some specialties are used in an off-label manner.

IV.) Administering the hormones; Remedies; Termination of Treatment

Any questions I have regarding this treatment have been answered to my satisfaction.

I understand that I will be responsible for administering the hormones prescribed to me at home.

I will conform and comply with the recommended dose and methods of administration.

I also agree to conform to the request for initial and subsequent blood tests, as required to monitor my hormone levels. I understand that failure on my part to follow my physician's recommendations in dosage and use of my hormones and medication may result in unwanted and potentially harmful side effects/results.

I understand that failure to have appropriate laboratory testing completed at the interval established by my physician and failure to follow up with my physician at the recommended appointments may lead also to adverse unwanted side effects. I also understand there are possible benefits associated with these procedures. I understand that no guarantee has been made to me regarding outcomes neither of this treatment, nor on resolution of my symptoms. I understand that not all patients receive the same degree of response.

I also understand that the benefits derived from therapy will cease and those derived from hormone therapy and

drugs that alter hormone levels may not reverse if the therapy is discontinued. I authorize Regenx to perform this treatment.

I understand they may be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to nutritional supplementation and hormone modulation therapy. I certify that I am under the regular care of another physician for all other medical conditions.

I understand that this is a specialized practice and does not hospitalize patients.

I also understand that I will continue under the care of my other physicians for any ongoing medical condition as well as for any medical consultation that I may need.

I ASSUME FULL LIABILITY FOR ANY ADVERSE EFFECTS THAT MAY RESULT FROM NON-NEGLIGENT ADMINISTRATION OF THE PROPOSED TREATMENT.

I WAIVE ANY CLAIM IN LAW OR EQUITY FOR REDRESS OF ANY GRIEVANCE THAT I MAY HAVE CONCERNING OR RESULTING FROM THIS PROCEDURE, EXCEPT AS THAT CLAIM PERTAINS TO NEGLIGENT ADMINISTRATION OF THE PROCEDURE.

I hereby confirm that the nature and purpose of portions of the aforementioned treatment are considered by some to be medically unnecessary and/or experimental, as there are no long-term studies documenting the results.

The risks involved and the possibilities of complications have been explained to me.

I fully understand that some aspects of the treatment to be provided may be considered experimental and unproven by scientific testing and peer-reviewed publication.

I understand that I may suspend or terminate treatment at any time, and hereby agree to immediately notify Regenx' physician of any such suspension or termination.

The undersigned certifies that HE/SHE has read and understands all the above, and as the Patient, agrees to and accepts the terms. I acknowledge I have been encouraged to ask any questions regarding this therapy.

To attest to MY FULL, COMPETENT, AND INFORMED CONSENT to this treatment, I hereby affix my signature to this Consent to Treatment.

4. Insurance and HRT

As you are aware, we are a non-participating provider with Medicare and Out of Network Providers which means we do not participate with any insurance company. If you belong to an HMO, Medicare or state benefit program, you must pay out of pocket all therapy costs generated by our office.

Disclaimer of Medicare/Private Insurance Benefit

Patient acknowledges that Regenx Medical Institute have not made any representation or warranty that the treatment or any portion thereof qualifies, or will qualify for reimbursement, or assignment under any Medicare, Medicaid and/or any other federal/state government or private insurance program.

Patient hereby covenants to Regenx Medical Institute, that he or she shall not submit any claims to Medicare or any other government program for any portion of the treatment at any time.

Patient agrees to indemnify Regenx Medical Institute, and its members and managers against any claim, action,

loss or suit and associates costs, including attorney's fees which result either directly or indirectly from submission by patient or his or her authorized agent or representative of a claim for any portion of the treatment to Medicare, federal/state government benefit program, or private insurance program.

Patient acknowledges that this agreement was executed before services were rendered, and that patient is not facing an urgent or emergency health situation.

5. Authorization to Release Healthcare Information

Patient's Name: Date of Birth:

Previous Name: Social Security #:

I request and authorize: to release healthcare information of the patient named above to: **RegenX Medical Institute**

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates

- All blood work data

- Body measurements, results, and clinical information that can be used as clinical data

- Other; as deemed necessary by your physician

I authorize the release of my saliva test results, blood testing and physical to the persons listed above. I understand that the persons listed above will be notified that I gave specific written permission before disclosure of these test results.

By signing this document I consent to and agree to all five consents, release forms and waivers presented.

Patient Name: Date:

Patient Signature:

Witness Name: Date:

Witness Signature: