CENTRAL TEXAS
Wellness & Rejuvenation
CENTER
where Health & Beauty come together

Patient Registration Form

Last Name:_____ **First Name:**_____ **DOB:**_____ **Age**:_____

Race: (circle one) Asian African American Caucasian Hispanic Native American Other:_____ **Height:**_____

Address:_____ **Apt #:**_____ **City:**_____ **State/ZIP Code:**_____

Social: _____-_____-_____ **Email:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Marital Status:_____ **Occupation:**_____

Emergency Contact Name:_____ **Phone:**_____

Please Read and Initial the following stating that you have read and understand the information

_____ I understand that I will be charged a $30.00 fee for any insufficient check written to CTWRC.

_____ I understand that CTWRC has a **24 hour** cancellation policy. I understand that I will be charged a $50.00 fee for any missed or cancelled appointment if less than a 24 hour notice is given.

Primary Care Physician:_____ **Phone:**_____ **Fax:**_____

Please List any Specialty Physicians and/or other:

Physician Name:_____ **Phone:**_____ **Fax:**_____

Physician Name:_____ **Phone:**_____ **Fax:**_____

How did you hear about us?_____

Reason for your visit today:_____

Past Medical History

Current Medication: (including supplements and/or over the counter Medicines)

Name:	Dosage:	Strength:

Drug Allergies: (including supplements and/or over the counter Medicines)

Name:	Dosage:	Strength:

Please CHECK the following that apply to **YOUR** medical history (current & past):

Anemia	☐	YES	☐	NO	High Cholesterol	☐	YES	☐	NO
Asthma	☐	YES	☐	NO	Kidney Disease	☐	YES	☐	NO
Arthritis	☐	YES	☐	NO	Mitral Valve Prolapse	☐	YES	☐	NO
Anxiety	☐	YES	☐	NO	Prostate enlargement	☐	YES	☐	NO
Breast Cancer	☐	YES	☐	NO	Prostate Cancer	☐	YES	☐	NO
Blood transfusion	☐	YES	☐	NO	Rheumatic Fever	☐	YES	☐	NO
Diabetes	☐	Type 1	☐	Type 2	Skin Cancer	☐	YES	☐	NO
Depression	☐	YES	☐	NO	Stroke	☐	YES	☐	NO
Glaucoma	☐	YES	☐	NO	Thyroid Disease	☐	YES	☐	NO
Gout	☐	YES	☐	NO	Tuberculosis	☐	YES	☐	NO
Heart Disease	☐	YES	☐	NO	Uterus Cancer	☐	YES	☐	NO
Heart Murmur	☐	YES	☐	NO	Organ Cancer	☐	YES	☐	NO
High blood pressure	☐	YES	☐	NO	Type of Organ Cancer:_____				

Past Surgical History

Please list any previous surgeries with approximate dates:

Surgical Procedures	Date

Cosmetic Surgery	Date

Family History

Please **Check All** that applies for **Family Members** including Parents, Grandparents, and Siblings. Please Specify Relation

Breast Cancer	☐ YES	☐ NO	Whom? :	_____
Colon Cancer	☐ YES	☐ NO	Whom? :	_____
Melanoma	☐ YES	☐ NO	Whom ?:	_____
Other Cancer	☐ YES	☐ NO	Whom ?:	_____
Anxiety	☐ YES	☐ NO	Whom ?:	_____
Stroke (CVA)	☐ YES	☐ NO	Whom ?:	_____
High Blood Pressure (HTN)	☐ YES	☐ NO	Whom ?:	_____
Heart Disease (MI/CAD)	☐ YES	☐ NO	Whom ?:	_____
Kidney Disease	☐ YES	☐ NO	Whom ?:	_____
Depression	☐ YES	☐ NO	Whom ?:	_____
Diabetes (DM)	☐ YES	☐ NO	Whom ?:	_____
If Yes……	☐ Type 1	☐ Type 2		

Social History

Do You Smoke? : ☐ YES ☐ NO If so, How many packs per day? : _____

If you smoked in the past, when did you quit? : _____

On average, how many times do you consume alcoholic beverages a week? : _____

Any use of illicit drug use? ☐ YES ☐ NO Details: _____

Gynecological History (WOMEN ONLY)

Please list or CIRCLE your Current Method of Birth Control

_____ Date:_____

Vasectomy IUD

Condoms Hysterectomy

Not sexually active Nat Family Planning

Birth Control Pill None

Birth Control Patch Birth Control Ring

Age of First Menstrual Period

Date: _____

1st day of Last Menstrual Period

Date: _____

Regular Cycles ☐ YES ☐ NO

Details: _____

Please circle all that may apply: Have you had any of the following?

HPV HIV Chlamydia

Warts HepB Gonorrhea

HSV HepC Tuberculosis

Syphilis

Please List other Sexual Transmitted Diseases:

_____

_____

Pregnancies

of pregnancies:____ # of Full Term Children: ____ # of Pre Term Children: ____

# of Abortions: _____ # of Miscarriages: _____ # of Living Children: _____

# of Adopted Children: _____ # of Vaginal Deliveries: _____ # of C-sections: _____

Date of Last:

Pap: _____ Normal ☐ Abnormal ☐

Colonoscopy: _____ Normal ☐ Abnormal ☐

Lipid Panel: _____ Normal ☐ Abnormal ☐

Thyroid Panel: _____Normal ☐ Abnormal ☐

Mammogram:_____ Normal ☐ Abnormal ☐

Bone Density (BMD):_____ Normal ☐ Abnormal ☐

Glucose: _____ Normal ☐ Abnormal ☐

Vitamin D: _____ Normal ☐ Abnormal ☐

Men Only

Prostate Exam:_____Normal ☐ Abnormal ☐

Colonoscopy: _____ Normal ☐ Abnormal ☐

Insurance Information

Although we do not accept insurance, we would like to know the following information in case an emergency arises.

Are you covered by insurance? ☐ YES ☐ NO Insurance through: ☐ **Work** ☐ **Husband** ☐ **Parent**

Insurance Plan: _____ Policy/ID #: _____ Group #: _____

Please provide information on Insurance Policy Holder:

Policy Holder Name: _____ DOB: _____ SSN: _____ Tel #: _____

Address: _____ City: _____ State: _____

Employer: _____ Tel #: _____

Blanket Assignment Authorization:

I hereby authorize release of medical information to CTWRC from any other provider who may treat me medically.

I authorize the release of any medical information necessary to process Insurance or Medicaid claim: and/or review for quality insurance purposes, I request that payment under the medical insurance program be made to CTWRC. I have received a copy of the Wellness and Rejuvenation Center Patient Bill of Rights and Responsibilities.

I understand that I am Financially responsible for ALL CHARGES

Signature: _____ **Date:** _____