New Hampshire
REGENERATIVE CENTER

WELCOME TO OUR OFFICE!

Full Name: _____ Date Of Birth: _____
Address_____ City_____ State_____ Zip_____
Phone: _____ Email: _____

Occupation: _____ Hours worked per week: _____
How did you hear about us? _____

Emergency Contact_____ Phone: _____

Current Medications/Supplements: _____
_____
_____

PAST MEDICAL HISTORY: ex) Surgeries, Accidents, Injuries, Family Medical History, etc.)
_____
_____
_____
_____

ALLERGIES: _____
_____

SULFA ALLERGY? YES NO (Please Indicate)

ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? YES NO N/A

HAVE YOU RECEIVED CORTISONE INJECTIONS? _____ When? (Month/Year) _____
What area of the body? _____

DO YOU HAVE A HISTORY WITH CANCER? _____ If yes, please list history below.
(Type, treatments, years, remission, etc.)
_____
_____
_____

Do you have a history of the following?

___Neck Pain ___Hip Pain ___Foot/Ankle Pain ___Shoulder Pain
___Knee Pain ___Sprains ___Diabetes ___Seizures
___Whiplash ___Abdominal Pain ___Nervous Tension ___Varicose Veins
___Headaches ___Arthritis ___High Blood Pressure
___Disk Problem ___Heart Attack ___Colitis
___Mid Back Pain ___Low Back Pain ___Overall Joint Pain
___Digestive Problems ___Broken Bones ___Stroke
___Numbing/Tingling anywhere in Body (If Yes, Explain Below)

Which of the above is the worst?

_____

How long have you had it?

_____

How often does it occur?

_____

When it is at its worst, how does it feel? (describe)

_____

What activities would you like to do if this was not a problem?

_____

Is there anything you once REALLY enjoyed doing, but are no longer able to do because of this pain?

_____

What have you tried to help relieve/get rid of this problem and how much did it help?

◆ Pain Medications…Helped: Little Some Much
◆ Exercise…Helped: Little Some Much
◆ Physical Therapy…Helped: Little Some Much
◆ Nutrition…Helped: Little Some Much
◆ Chiropractic…Helped: Little Some Much
◆ Stretching…Helped: Little Some Much
◆ Cortisone Injections…Helped: Little Some Much

Additional concerns /comments: _____

_____

_____

_____

Please indicate of your consumption for each:

	None	Light	Moderate	Heavy
Salt	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Water	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____

Do you have any of the following today?

___Sunburn ___Inflammation
___Headache ___Severe Pain
___Open Cuts ___Skin rash
___Poison Ivy ___Bruises/Burns
___Cold/Flu symptoms

We are pleased to have professional experienced & licensed providers on staff that specialize in treating a wide variety of conditions, both chronic and acute in nature.

LISA PEPPE, MSN, APRN, FNP-BC

Regenerative Therapies/Injections, Neuropathy Treatments, Trigger Point Injections, Laser Treatments, P.R.P (Platelet Rich Plasma), Nutrient Injections, Ozone Injections

&

TAYLOR DOXSEE, L.M.T. / CPT

Medical/Therapeutic Massage, Joint Mobilization, Functional Movement, Manual Therapy, Posture Correction, Strength Training/Conditioning, Titleist Performance Training (Golf), Weight Loss Training

OFFICE POLICIES

New Hampshire Regenerative Center has adopted the following policies. Thorough understanding of these policies is necessary to effectively serve all of our valued patients.

1. Payment is expected at the time of service. We do not directly bill your insurance company, however, if requested, we will provide you with the necessary information for you to submit to your insurance company.

2. If you are late for an appointment, you will receive only the remainder of the time left in your time slot and you will be responsible for the full session price.

3. Missed appointments without a 24-hour notice of cancellation will incur a fee equal to 60% of the missed appointment.

I hereby authorize the Healthcare Provider to provide any and all forms of treatment, evaluation, x-rays, and therapy that may be indicated in connection with the care of the patient above, and further authorize and consent that the Healthcare Provider chooses and employs such assistance as (s)he sees fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the Healthcare Provider. I agree to pay for all services rendered in this office.

Signature_____Date_____

Parent/Guardian Signature _____

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.
New Hampshire Regenerative Center uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.
New Hampshire Regenerative Center will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.
New Hampshire Regenerative Center may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.
New Hampshire Regenerative Center may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.
You may complain to the Privacy Officer Dr. Thomas Pratt and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

New Hampshire Regenerative Center must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms and of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Kayla Leo (Office Manager) at (603) 945-1945.

_____ _____

Printed Patient Name Date

_____ _____

Patient Signature Date