Medical History

Have you ever been diagnosed or treated for the following? (if yes, please specify):

Yes or No Heart Disease? _____

Yes or No High blood pressure? _____

Yes or No Cancer? _____

Yes or No Diabetes? _____

Yes or No Thyroid disease? _____

Yes or No Kidney disease? _____

Yes or No Gastrointestinal disease? (stomach, colon, liver, etc) _____

Yes or No Infectious diseases? (hepatitis, TB, AIDS, Lyme) _____

Yes or No Major Surgery? _____

Yes or No Difficulty with healing of wounds? _____

Yes or No Any keloids, bad scars or excessive bleeding? _____

Are you currently taking any blood thinners or have any history of excessive bleeding? _____

Insurance Information

Primary Insurance Co:: _____ ID #:: _____ Grp #: _____

Secondary Ins Co:: _____ ID #:: _____ Grp #: _____

Policy Holder name: _____ ID #:: _____ DOB: _____

Policy holder address: _____

Policyholder SS #: _____ Policyholder Sex: _____ Copay Amount: _____

I have read and understand the HIPAA policy and Privacy Notice. I have been offered a copy of this notice. I hereby assign my insurance benefits to be paid directly to my healthcare provider. I authorize Millennium Wellness and Regenerative Medicine, LLC, Inc. to bill my insurance and release medical record information. I consent to treatment of services rendered by my Provider and/or staff members. I understand services rendered may not be an insurance benefit and that I am responsible for non-covered services. Payment is due at the time of service. I am responsible for any balance on my account. I authorize my Provider's office to contact me by mobile phone, email or text message.
To the best of my knowledge the above information is complete and accurate.

Signed: _____ Date: _____

Parent/Guardian Signature (if minor): _____ Date: _____