The Burress Center for
Cellular and Regenerative Medicine

Patient Information Sheet

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ Email Address: _____

Social Security #: _____ Birth Date: _____ Age: _____

Gender: _____ Marital Status: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Primary Physician: _____

Referral Source: _____

Allergies_____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

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Health History

Please check to indicate if you have or have had any of the following conditions:

□ Neck Pain/Stiffness
□ Back Pain/Stiffness
□ Nervousness
□ Sleeping Difficulties
□ Fainting
□ Stomach Problems
□ Pins/Needles in Arms
□ Pins/Needles in Legs
□ Loss of Memory
□ Jaw Problems
□ Dizziness
□ Shortness of Breath
□ Light Bothers Eyes
□ Depression
□ Chest Pain
□ Fever
□ Allergies
□ Blurred Vision
□ Sudden Weight Loss
□ Arm/Hand Pain
□ Leg/Knee Pain
□ Headaches
□ Asthma
□ Bowel Changes
□ Bladder Changes
□ Nausea
□ Fatigue
□ Tension
□ Constipation

Please check to indicate if you have or have had any of the following:

□ AIDS/HIV
□ Alcoholism
□ Allergy Shots
□ Anemia
□ Anorexia
□ Appendicitis
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Breast Lump
□ Bronchitis
□ Bulimia
□ Cancer
□ Cataracts
□ Chemical Dependency
□ Chicken Pox
□ Diabetes
□ Emphysema
□ Epilepsy
□ Fractures
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Gout
□ Heart Disease
□ Hepatitis
□ Hernia
□ Herniated Disc
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Liver Disease
□ Measles
□ Migraines
□ Miscarriage
□ Mononucleosis
□ Multiple Sclerosis
□ Mumps
□ Osteoporosis
□ Pacemaker
□ Parkinson's Disease
□ Pinched Nerve
□ Pneumonia
□ Prostate Problems
□ Prosthesis
□ Rheumatoid Arthritis
□ Rheumatic Fever
□ Scarlet Fever
□ Stroke
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Tumors/Growths
□ Ulcers
□ Vaginal Infections
□ Venereal Disease
□ Whooping Cough
□ Other _____

Are you currently under drug and/or medical care? □ Yes □ No If yes, explain _____

Please list any medications you are currently taking: _____

Please List any surgeries and/or hospitalizations you have had (type and date): _____

Please list any allergies: _____

Is there a family history of any of the following? □ Heart Disease □ Cancer □ Diabetes □ Arthritis □ Other _____

Do you exercise? □ Frequently □ Moderately □ Occasionally □ Not At All

Do your work activities mostly involve: □ Sitting □ Standing □ Light Labor □ Heavy Labor

What is your daily/weekly intake of the following: □ Caffeine _____cups/day □ Alcohol _____drinks/day
□ Cigarettes _____packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGN _____ **DATE** _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

LaJetta Kerrison	**352-259-7994**

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person(s) listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified or changed in any way.

Name of Patient or Representative (Printed): _____

Patient or Representative Signature: _____ Date: _____

□ Patient Refused to Sign □ Patient Was Unable to Sign Because_____