LifeStream HEALTH CENTRE & MED SPA

New Patient Registration

Date of Birth	Age	Last Name	First Name	Middle Initial

Address _____ Address 2 _____

City _____ State _____ Zip _____

Cell Phone # _____ Home Phone # _____

Email _____ Social Security # _____

Race _____ Ethnicity _____ Language _____ Marital Status _____

Emergency Contact

Name _____ Telephone # _____ Relationship _____

HIPAA:

LifeStream's Privacy Practices are available on our website at www.Lifestreammed.com or upon request at the front desk. The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices pursuant to HIPPA. The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPPA, State law, and Federally. Patient records are subject to electronic transfer.

I authorize the following individual(s) to have **ACCESS** to my medical records, including all labs and images:

Printed Name	Relationship

Cancellation Policy:

Missed appointments or late cancellations are costly to everyone. Many appointments must be scheduled several days or weeks in advance to accommodate individual schedules. Last minute cancellations often leaves a desirable time slot unfilled. Therefore appointments cancelled without a 24-hour notice will be subject to a $25.00 fee. "No-Shows" will be subject to a $50.00 fee.

If there is any question regarding this policy, it may be discussed with the office manager, otherwise my signature below indicates that I understand and will abide by this policy.

Patient Signature: _____ Today's Date: _____

How did you hear about us? _____

Patient Name: _____

Family history of:

Cancer No ☐ Yes ☐

If yes, what kind: _____

Diabetes No ☐ Type I ☐ Type II ☐

High Blood Press. No ☐ Yes ☐

Personal History of:

Cancer No ☐ Yes ☐

If yes, what kind: _____

Diabetes No ☐ Type I ☐ Type II ☐

High Blood Press. No ☐ Yes ☐

Personal use:

Tabacco/Nicotine Use:	None ☐	Occasional ☐	Moderate ☐	Every Day ☐
Alcohol use:	None ☐	Social ☐	Occasional ☐	Moderate ☐

Female Questionnaire

Irregular Period	No ☐	Yes ☐	Ovarian Cyst	No ☐	Yes ☐
Missed Periods	No ☐	Yes ☐	Ovarian Mass	No ☐	Yes ☐
Last Menstrual Period:			Abnormal Pap (ever)	No ☐	Yes ☐
Painful Intercourse	No ☐	Yes ☐	Abnormal Mammogram (ever)	No ☐	Yes ☐
Vaginal Discharge/Itching	No ☐	Yes ☐	Last Mammogram:		
Ever had an STD	No ☐	Yes ☐	Current form of Contraception:		
Through/In Menopause	No ☐	Yes ☐			

Past Surgeries	Date

Pharmacy Information

If you ever might need a prescription called into a pharmacy from our office, we will need the name and the phone number of a pharmacy of your choice (if your pharmacy of choice changes, be sure to notify the staff when calling to request a prescription refill)

Pharmacy Name _____ Pharmacy Phone # _____