THE INSTITUTE OF ADVANCED BODY SCULPTING

PATIENT REGISTRATION

Please let us know how you were referred to our practice:

Websites: drtroell.com:___ Google: ___ Yahoo:___ Bing:___ Other:___

Key Word (s) written to find website: _____

Friend (If so name of friend): _____Health Care Provider:_____

Name: **Last, First Middle Initial**	**Social Security Number:**	**Birthdate:**	**Sex:** **Male** **Female**
Address:	**Home Phone: ( )** **Work Phone: ( )** **Cell Phone: ( )**		
Occupation: **Pharmacy Number:**	**Email Address** _____		
Marital Status: **Single Married Divorced Other**	**Emergency Contact:** **Name:** **Phone Number:**		

I SWEAR THAT THE MEDICAL & DEMOGRAPHIC INFORMATION PROVIDED IS TRUE. I HEAREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NEEDED TO PROCESS ANY INSURANCE CLAIM, MY MEDICAL INSURANCE BENEFITS ARE TO BE PAID DIRECTLY TO DR.TROELL, AND I AGREE TO PAY FOR ALL CHARGES NOT PAID BY MY INSURANCE COMPANY45 DAYS AFTER BILLED. IN THE EVENT THIS ACCOUNT IS REFERRED TO AN ATTORNEY OR COLLECTION AGENCY FOR COLLECTION, I AGREE TO PAY REASONABLE ATTORNEY'S FEES. OR ANY 3RD PARTY FEES & COURT COSTS FOR COLLECTIONS. THERE WILL BE A 5% PROCESSING FEE ADDED TO ANY PAYMENT USING FINANCE COMPANIES. I AUTHORIZE DR.ROBERT TROELL TO DISCLOSE AND DISCUSS ANY INFORMATION WITH MYSELF THROUGH EMAIL.

X_____ Date_____

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Name of Patient: (Last)_____(First)_____Age: ____ Sex: M / F

Height: _____ Weight: ____Primary Care Physician_____ Telephone_____

Pharmacy_____ Telephone_____

Medications you're **ALLERGIC** to: _____

In the following questions, please circle **YES** or **NO**, and Circle the one you **HAVE:**

1. Are you now in good health?……...Yes…..No

2. Do you have or have you had any of the following **medical problems**?
   a. Heart murmur, rheumatic fever, or mitral valve prolapsed …..… Yes/No
   b. Heart attack, abnormal heartbeat or angina…….. Yes/No
   c. High blood pressure……..... Yes/No
   d. Stroke, cerebrovascular accident, TIA's……..... Yes/No
   e. Cardiac pacemaker, heart surgery, artificial valves…… Yes/No
   f. Artificial joints or transplants…….... Yes/No
   g. Allergies, hives or skin rashes…… Yes/No
   h. Sinus trouble or postnasal drip…… Yes/No
   i. Lung problems, asthma, emphysema, shortness of breath… Yes/No
   j. Diabetes or low blood sugar……. Yes/No
   k. Chronic cough or coughing up blood…… Yes/No
   l. Seizures, epilepsy or fainting spells…… Yes/No
   m. Hepatitis, jaundice or liver disease…….. Yes/No
   n. Arthritis, back or neck problems……..…… Yes/No
   o. Stomach ulcers, gastritis……... Yes/No
   p. Kidney stones, bladder or kidney infections, dialysis……... Yes/No
   q. Sexually transmitted disease……... Yes/No
   r. Herpes or cold sores, fever blisters……... Yes/No
   s. AIDS or HIV positive……..……. Yes/No
   t. Emotional or psychiatric problems…… Yes/No
   u. Tuberculosis……. Yes/No
   v. Hiatal hernia, indigestion, reflux disease…….. Yes/No
   w. Gallbladder or pancreas disorders……..... Yes/No
   x. Thyroid disease, goiter…….…... Yes/No
   y. Received blood transfusions……. Yes/No
   z. Dry eyes, glaucoma, cataract……...…. Yes/No
3. Have you or a family member reacted poorly to anesthesia?……. Yes/No
4. Have you ever had cancer or a tumor?…… Yes/No
5. Do you have a bleeding problem?……... Yes/No
6. Do you smoke?……... Yes/No
7. Do you drink alcohol? Light (1per day), Moderate (2 per day), Heavy… Yes/No
8. Do you currently use street or illicit drugs?……. Yes/No
9. Do you wear dentures or a removable dental device?…… Yes/No
10. Do you wear contact lenses?…… Yes/No
11. Do you wear a hearing aid?……. Yes/No
12. WOMAN- Are you pregnant or nursing?…… Yes/No
13. List all **medications** you're taking: (name, dose, frequency)
    _____
    _____
14. List all previous **surgeries**:
    _____
    _____

I CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT AND ACCURATE.

Signed by Patient: X_____

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Provider Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. I authorize Dr. Troell and his staff to disclose and discuss any information with myself through email including my medical records and allow telemedicine communication. Please review carefully.

We use health information about you for treatment, to obtain payment for treatment, administrative purposes, and to elevate the quality of care you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for the law enforcement in specific circumstances. In any other situation we will ask you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any further uses and disclosure.

We may change our policies at any time before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can request a copy of our notice at any time

<u>Individual Rights</u>
In most cases you have the right to look or get a copy of health information about you that was used to make decisions about you. If you request copies we will charge you only normal photocopy fees ($0.60 per sheet). You may also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your record is incorrect or if important is missing, you have the right to request that we correct the existing information or add the missing.

<u>Complaints</u>
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our office. You may also send a written complaint to the U.S. Department of Health and Human Service.

<u>Our Legal Duty</u>
We are required by law to protect privacy of your information provide this notice about our information practices, follow the information practices described in this notice, and obtain your acknowledgement to receipt of this notice.

X_____ **Date:**_____