

LONGEVITY INSTITUTE INDIANA

Patient Registration Form

Name _____ Female__ Male__ () S () M () W () D

Address _____

City _____ State _____ Zip Code _____

Phone H: () _____ C: () _____ W: () _____

Email Address _____

May we add you to our mail/email list in order to receive special service discount coupons? () Y () N

Birth Date ____ / ____ / ____ Age ____ Social Security _____ - ____ - ____

Occupation _____ Employer _____

Employer Address _____

City _____ State _____ Zip Code _____

PATIENT BILLING INFORMATION

Name _____ Relationship to Patient _____

Address of above if differs from Patient _____

City _____ State _____ Zip Code _____

Guarantor's of DOB ____ / ____ / ____ Social Security _____ - ____ - ____

Employer of Guarantor _____

Employer Address _____



City _____ State _____ Zip Code _____

Employer Phone Number _____

Patient Emergency Contact Information: Name _____

Phone _____ Relationship _____

FEMALE PATIENTS

Regular menstrual periods? Y () N () Method of birth control _____

Pregnancies Y () N () # of live births _____ Miscarriages _____

Menopause Y () N ()

TO BE COMPLETED BY PATIENT OR GUARDIAN. PLEASE PRINT CLEARLY.

Reason for visit _____

Any history of the problems you are in for today? Y () N () For how long? _____

Any other illness or disease not mentioned that you may have? _____

Current Medications

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____



Hospital Admissions (indicate year and reason for admission)

1) _____

2) _____

3) _____

Check all that apply (past and present)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Scarring | <input type="checkbox"/> Hives | <input type="checkbox"/> Irregular Pulse |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Frequent Sun | <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Depression |



- Allergies Venereal Disease Abnormal Moles Rash
 Thyroid Disease

Alcohol intake _____ times per week Cigarettes _____ times per week for _
years

Exercise sessions _____ times per week Coffee/Tea _____ times per day

ACKNOWLEDGEMENT OF UNDERSTANDING PRIVACY POLICIES

Longevity Institute's notice of Privacy Procedures and Policies is clearly posted in the office and a hard copy is available upon request. As stated, the terms of this notice may change without prior warning. You may request a copy of the current policy either in the office or in writing at:

**Longevity Institute Indiana
10291 N. Meridian Street, Ste. 300
Indianapolis, IN 46290**

You have the right to restrict how your Patient Health Information (PHI) is disclosed for treatment, payment or health care operations. Longevity is not required to agree to this restriction, but if we do agree, we are bound by it.

By signing this form, you consent to our use and disclosure of your PHI for this treatment, payment and healthcare operations. You have the right to revoke this consent at any time by requesting it in writing to the address above. Revocation of this consent will not affect disclosures already made.

I, _____, have read the Privacy Procedures and Policies and consent to the disclosure of my PHI for treatment, payment and health care operations.



Signature of Patient or Guardian

Relationship to Patient

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges. I also understand that I am responsible for any attorney fees, court costs or other charges that may occur if for some unforeseen reason my account is turned over to a collection agency.

**PAYMENT IS REQUIRED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS
HAVE BEEN MADE**

Patient Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Longevity Institute to release any medical or incidental information that may be necessary to either medical care or in the processing of medical information/insurance forms.



Patient Signature _____ Date _____

MISSED APPOINTMENTS POLICY

There will be a \$25.00 charge to your account for missed appointments or not cancelled 24 hours prior to the scheduled time. After three missed appointments a review will take place and a determination will be made by Dr. Sumrall whether Longevity will continue medical care.

I HAVE READ AND UNDERSTAND THE POLICY
REGARDING MISSED APPOINTMENTS

Signature of Parent or Responsible Party

Date

