CLIENT CONTACT INFORMATION

First Name:_____ MI:_____ Last Name_____

Billing Address: Street: _____

City:_____ State:_____ Zip Code: _____

Shipping Address (if different from billing address):

Street: _____

City:_____ State:_____ Zip Code: _____

Phone Numbers: Please check your contact preference.

❑ Home:_____ ❑ Work: _____

❑ Cellular:_____ ❑ **Email:** _____

❑ Pager:_____ ❑ Fax: _____

____Private Fax____Public Fax

Date of Birth: Gender:

Month:_____ Day:_____ Year: 19_____ ❑ Male ❑ Female

Emergency Contact:

First Name:_____ Last Name: _____

Address: _____

City:_____ State:_____ Zip Code: _____

Phone:_____ Relationship: _____

Whom may we thank for referring you? _____

What are your favorite hobbies/interests? _____

_____

CONFIDENTIAL HEALTH HISTORY

Today's Date: _____

NAME: _____ **Birth date :** ___/___/___ **Age:** _____

Marital Status: _____ **Level of Education**: _____
Current Occupation: _____ **Is your occupation enjoyable?** *Y / N*

Is it stressful? *Y / N* **Is it fulfilling?** *Y/ N* **Hazardous Material exposure?** *Y / N*

If retired, what is your main hobby? _____
When did you retire? _____ Are you happy in retirement Y /N

YOUR GOALS: *What you hope to achieve in your participation in this Program?*

_____
_____
_____

PLEASE LIST ACTIVE MEDICAL PROBLEMS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PRESCRIPTION & OVER the COUNTER meds are you currently taking:

_____
_____
_____
_____
_____
_____

ALLERGIES: - DRUGS: **FOOD**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

NUTRIENTS / SUPPLEMENTs are you taking:

_____
_____
_____
_____
_____
_____

CONDITIONS: *Check any other conditions you have ever had in the past, & indicate what year*

___ AIDS / HIV+	___Allergies / Asthma	___Anemia	___Alcohol / drug problem
___ Anorexia / Bulemia	___Arthritis	___Atrial Fibrillation	___Anxiety / Panic Disorder
___ Back pain	___Bleeding Disorder	___Candida / Yeast	___Cancer – Specify: _____
___ Chronic Fatigue	___Crohn's Disease	___Colitis	___Diabetes -Type: I II
___ Depression	___Emphysema	___Epilepsy / Seizures	___Fibromyalgia
___ Glaucoma	___Goiter	___Gout	___Hiatal Hernia / Reflux
___ Heart Disease	___High cholesterol	___Irritable Bowel	___Hypertension / High BP
___ Jaundice	___Kidney Disorder	___Kidney Stones	___Liver Disease
___ Hepatitis	___Migraines	___Multiple Sclerosis	___Osteoporosis
___ Pancreatitis	___Parasites	___Parkinson's	___Pelvic Infl Disease
___ Pneumonia	___Polio	___Prostate Problem	___Rheumatic Fever
___ Root canal	___Sinusitis	___Stroke / TIA	___Suicide Attempt
___ Thyroid problem	___TMJ	___Tooth Abscess	___Tuberculosis
___ Ulcers	___Urinary Infection	OTHER: _____	

_____

CURRENT or RECENT SYMPTOMS: *Check any symptoms that you have had recently.*

___ Nose bleeds
___ Abdominal Pain
___ Difficulty swallowing
___ Kidney pain
___ Change in headaches
___ Bone pain
___ Excessive thirst
___ Recent change in bowel habit
___ Weight loss - unexpected

___ Shortness of Breath
___ Acid reflux
___ Loss of appetite
___ Blood in urine
___ Double vision
___ Unusual bruising
___ Rapid heart beat

___ Swollen ankles
___ Black tarry stools
___ Persistent nausea
___ Frequency of urination
___ Dizzy / spinning
___ Prolonged bleeding

___ Snoring excessively
___ Bright blood in stool
___ Mood swings
___ Urgency of urination
___ Eye pain
___ Bloated

Other Symptoms: _____

HOSPITALIZATIONS: *Please include Surgeries, illnesses, severe accidents, births, miscarriages:*

Year:	Procedure	Reason:	Outcome:

FAMILY HISTORY: *Please complete health Information about your family:*

Relation	**Age:**	**State of h**	**Age at Death:**	**Cause of d**	**Check √**	**if your blood rels had any of the following Disease:**	**Relation to you:**
Father						Arthritis / Gout	
Mother						Asthma / Hay Fever	
Brothers						Cancer: Where:	
						Drugs / Alcohol	
						Diabetes	
						Heart Disease	
Sisters						High Blood Pressure	
						Osteoporosis	
						Stroke	
						Tuberculosis	

RECENT TESTS:
If you have had any of these tests, please complete:

TEST:	Dat	Reason:	Result:
Chest X Ray			
EKG			
EGD (Stomach			
Colonoscopy			
Ultrasound			
CAT Scan			
MRI Scan			
Bone Density			
Other			

HEALTH HABITS:
***Which substances do you consume*:**

Substance	How Much?
Caffeine	**cups,cans**
Cigarettes	**packs / day x**
Are you interested in quitting? Y / N	
Alcohol	**Type Amount**
Drugs Y N	**What Amount**
Chew tobacco Y N	**Amount Yrs**
Nutrasweet	Servings per day:
Saccharin	Servings per day:

FOR WOMEN:

Date of 1st day of last period: _____ Birth control method: _____ Are you pregnant? Y / N

Date of last PAP test: _____ *normal / abnormal* Date of last Mammogram: _____ *normal / abnormal*

Date of Menopause: _____ Have you ever had an abnormal pap? Y / N When? _____

Review this list of symptoms and check the ones that apply.

___ PMS	___ Hot flashes	___ Sleep problems
___ Uterine Fibroid	___ Vaginal Dryness / Pain	___ Mood swings
___ Fibro-cystic Breasts	___ Loss of interest in sex	___ Painful Periods
___ Ovarian Cysts	___ Leak Urine	___ Unusual vaginal discharge
___ Irregular periods	___ Painful periods	___ Cramps / clots w periods
___ Vaginal irritation	___ Painful sex	___ Spotting after menopause
___ Increased fat around hips / thighs	___ Endometriosis	___ Problems w Infertility

FOR MEN:

Date of last prostate exam: _____ *normal / abnormal*

Review this list of symptoms and check the ones that apply:

.___Lowered interest in sex Erections less firm____Difficulty in initiating urine stream Getting up at nite to urinate_Enlarged prostate Can't maintain an erection_ Slowing urinary stream__Problems w Infertility

__ Bladder not emptying completely

REVIEW THESE SYMPTOMS OF AGING AND CHECK THE ONES THAT APPLY.

Thyroid

___ Dry hair
___ Infertility
___ Migraines
___ Losing hair
___ Constipation
___ Fluid retention
___ Crave caffeine
___ Dry coarse skin
___ Diets don't work
___ Cold hands & feet
___ Elevated cholesterol
___ Low body temperature
___ Fatigue / Exhaustion
___ Decreased memory
___ Brittle unhealthy nails
___ Unable to lose weight
___ Daytime drowsiness
___ Foggy / spacey mind
___ Depression / Anxiety
___ Low ambition / motivation
___ Decreased concentration
___ Fibromyalgia / Chronic fatigue
___ Feel cold / dress more warmly

Cardio-Respiratory:

___ Palpitations
___ Decreased stamina
___ Decreased endurance
___ Run out of breath sooner
___ Easily exhausted with exercise

Adrenal:

___Palpitations
___Salt craving
___Sugar craving
___Panic attacks
___Muscle tension
___Easily frustrated
___Excessive hunger
___Prone to infection
___Low blood pressure
___Poor stress tolerance
___Low back pain (SI joints)
___Light headed on standing up
___Racing mind prevents sleep
___Need sunglasses in bright sun light

Metabolism:

___Can not skip meals
___High blood pressure
___Headache w missed meal
___Cravings for sugar & carbs
___High cholesterol / triglyceride
___Increased fat around abdomen
___ Prone to inflammation and bursitis
___Periods of low energy relieved w food
___Shaky / weak episodes – Eating helps
___Jittery / irritable episodes – Eating helps
___Alternating between high and low moods
___Alternating between sluggish and high energy

Skin / Integumentary:

___ Dry skin
___ Thin Lips
___ Graying hair
___ Skin blemishes
___ Thin brittle nails
___ Tendency to bruising
___ Thinned skin –hands, face, arms
___ Thinning hair – scalp, armpits, legs
___ Wrinkling skin – face, neck, hands & arms
___ Sagging skin – under eyes, arms, face, breasts

Neuro-cognitive:

___Loss of esteem
___Feeling hopeless
___Feeling defeated
___Loss of confidence
___Vision deteriorating
___Hearing deteriorating
___Memory deteriorating
___Sense of powerlessness
___Decreased sense of well being

Gastrointestinal:

___ Feel full faster
___ Slower digestion
___ Fullness after meals
___ Eat less / smaller meals
___ Indigestion / Hyperacidity
___ Burping or belching after meals
___ Decreased sense of taste / smell

Muscles/Joints:

___Osteoporosis
___Aches and Pains
___Loss of strength
___Body & joints stiff
___Balance deteriorating
___Coordination deteriorating
___Thinning muscles – buttocks, arms, legs

DIET: **Are you on any special diet?** *(Please specify:____* Successful? Y / N

List which diets have been effective in the past: _____

STRESS:

Rate your current stress level: *Extreme; High; Medium; Low* *(Please circle)*
How long has it been like this? _____
You expect this to last a *short medium long* period of time. *(please circle)*
Do you have a solution? Y / N
Do you need help? Y / N

EXERCISE: ***Please circle which you do.***

Aerobic Weights Walking Other:_____
How long are your workout sessions? _____

How many days / week? _____

SLEEP: *Please check the symptoms that you notice.*

___ Trouble getting to sleep – racing mind
___ Sleep not as restful / Wake up not rested
___ Wake up through night feeling like you are choking or having a smothered sensation
___ Your partner has noticed very heavy snoring during sleep
___ Your partner has noticed that you stop breathing through the night with heavy snoring
___ Daytime drowsiness or sleepiness especially with periods of inactivity
___ Toss and turn through night / wake frequently through night

Take a moment to reflect on your response to the following question:
On a scale of 0 – 5 (5 being the highest response), circle your response:

How important and committed are you to a longevity program? 0 1 2 3 4 5

Jack Palmer, M.D., Inc.
901 Dover Dr. #121
Newport Beach, CA 92660
949-644-4114
JackPalmermd.com

AUTHORIZATION TO BILL CREDIT CARD

Patients are responsible for any balance due.
We accept payment by cash, check, American Express, Visa or MasterCard.
We require full payment at the time of service. We request that our patients give us permission to process their credit card for their services rendered, such as, copays, deductibles, products, treatments.

We will keep patient credit card billing information on record as a convenience to our patients and may process your credit card on the next business day for services rendered.

We hold client billing and credit card information in strict confidence and take secure steps to protect Confidential Information from unauthorized disclosure or use.

By signing below, you acknowledge that you have given us authorization to process your credit card as needed to pay outstanding balances, products purchased or services rendered at our clinic.

Last four digits of credit card _____

Patient signature_____Date_____

JACK PALMER, M.D. PATIENT REGISTRATION

NOTICE OF PRIVARCY PRACTICES

Revised Date: September 23, 2015 THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU WISH TO REQUEST A DETAILED VERSION OF THIS PRIVACY PRACTICE NOTICE, PLEASE CONTACT THE PRIVACY OFFICER OR VIEW THE FORM ON OUR WEBSITE AT Jackpalmermd.com. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information. This facility will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below (Including Marketing and Selling of PHI), the Facility will obtain a written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. **The Facility reserves the right to change the Facility's privacy practices and this Notice**. Uses and Disclosures: We may use and disclose your protected health information (PHI) in the following ways: ⏐ For purposes of treatment, payment, and hospital operations. ⏐ When release is required by law, including: for military purposes, for law enforcement requests, for national security reasons, or for healthcare regulatory or accrediting agencies. ⏐ In emergency situations or for health and safety reasons. ⏐ To medical examiners, coroners, or funeral directors. ⏐ To organ, tissue, and other donation organizations. ⏐ To contact you about appointment reminders or to tell you about other health-related benefits and services. ⏐ For our directory. ⏐ For Worker's Compensation requests. ⏐ To people who are involved in your care. ⏐ For other purposes as set forth in the full Notice of Privacy Practices. **All other uses and disclosures by Jack Palmer, MD practice will require us to obtain from you a written authorization. Your Rights:** ⏐ **Restrictions**: To ask us to limit the information we share, including a right to not have your information disclosed to your health plan when you pay for your services yourself. We will consider requests on an individual basis. ⏐ **Confidential communications**: To receive your confidential health information by alternate addresses, telephone numbers, or fax numbers. ⏐ **Access**: To inspect or receive copies of your medical record (Fee required). ⏐ **Amendments**: To request changes be made to your health information. (The request will be considered on an individual basis.) ⏐ **Accounting**: To receive a list of our disclosures of your health information. ⏐ **This notice:** To ask for a copy of our full privacy notice. ⏐ **Complaints**: If you feel your privacy rights have been violated, please contact the hospital departments listed below to file a complaint with the hospital. You may also complain to U.S. Department of Health & Human Services Office of Civil Rights. You will not be retaliated against for filing a complaint. **Our Duties**: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice. Updates to this notice are effective for all PHI we maintain. We must provide notification to you of a breach of unsecured PHI. **REVISIONS TO THE NOTICE OF PRIVACY PRACTICES** The Facility reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The Facility will also post the revised version of the Notice in the Facility. **COMPLAINTS** If you believe your privacy rights have been violated, you may file a complaint with the Facility and/or to the Secretary of HHS, or his designee. If you wish to file a complaint with the Facility, please contact Jack Palmer MD, if you wish to file a complaint with the Secretary, please write to: http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html CONTACT INFORMATION If you have any questions or for clarification on anything contained within this notice, please contact Jack Palmer, MD at 949-644-4114 or write to 901 Dover Dr. #121, Newport Beach, CA 92660.

I acknowledge that I have had an opportunity to review the Notice of Privacy Practices.

Signature of Patient/Responsible Party _____ Date_____

Name of Patient/Responsible Party (Print)_____

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN 30 DAYS OF THE DATE OF MY SIGNATURE BELOW STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814 or at www.cmanet.org. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from as confirmed by my initials immediately below.
Earlier effective date:_____ Patient's Initials:_____

ARTICLE 7: I have read and understood all of the information in this pamphlet, including the Introduction to the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ Dated:_____, _____
(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship:_____

PHYSICIAN'S AGREEMENT TO ARBITRATE
In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 5 above.

_____ Dated:_____, _____
(Physician or Duly-Authorized Representative)

---------- ----------
Title—e.g., Partner, President, etc. Print name of Physician, Medical Group, Partnership or Association