ASPIRE HEALTH Patient Registration Form

Name (required)

_____ _____

First Name Last Name

Gender (required)

☐ Female ☐ Male

Date of Birth (required)

_____/_____/_____

Address (required)

Address Line 1 (required) _____

Address Line 2 _____

City (required) _____ State (required) _____

ZIP Code (required) _____

Phone (required)

(_____) _____ - _____

Alternate Phone

(_____) _____ - _____

Email (required)

_____

EMERGENCY CONTACT INFORMATION

Emergency Contact (required)

_____ _____

First Name Last Name

Emergency Contact Phone Number (required)

(_____) _____ - _____

Relationship (required)

_____

ADDITIONAL MEDICAL CONTACT(S)

Family or Individual Physician (required)

_____

Physician Phone Number (required)

(_____) _____ - _____

PATIENT ACKNOWLEDGEMENT

Reason for Visit to Aspire Health (required)

_____

I have completed the above information to the best of my ability and understand that this information will only be used in regards to consult / treatment provided by Aspire Health.

Signature (required)

_____

Date (required)

_____/_____/_____

PATIENT MEDICAL HISTORY

Medications / Supplements (required)

Please list all current medications including vitamins / herbs / supplements. If none, enter N/A.

_____

_____

Allergies (required)

Please list any known allergies. If none, enter N/A.

_____

_____

Recent or Applicable Hospitalizations or Surgeries (required)

If none, enter N/A.

_____

_____

Patient Health History

Please indicate all conditions applicable to you

☐ Kidney Disease

☐ Cancer

☐ Radiation or Chemotherapy

☐ Stroke

☐ Congestive Heart Failure

☐ Vascular Disease

☐ High Blood Pressure

☐ Diabetes

☐ Heart Attack

☐ Shortness of Breath

☐ Chest Pain

☐ Arthritis

☐ HIV / Hepatitis

☐ Thyroid Disease

☐ Pregnant or trying to get pregnant

☐ Leber's optic neuropathy

☐ Any current infection/Illness _____

☐ Blood clotting defect

☐ Breastfeeding

Do you have any other health problems or medical conditions? *Please list:*

_____

_____

Please add any additional medical information that is relevant to you and not previously disclosed above.

_____

_____

PATIENT ACKNOWLEDGEMENT

I have completed the above information to the best of my ability and understand that this information will only be used in regards to consult / treatment provided by Aspire Health.

Signature (required)

_____

Date (required)

_____/_____/_____

CONSENT FOR PHOTOS

☐ I give consent for photos to be taken. *(Use includes but is not limited to social media and advertising)*