Institute for Progressive Medicine

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www.iprogressivemed.com www.hormonepellets.com

Medical Doctor Return Patient Form

Today's Date: ____/____/____

Name: _____ Birth Date: ____/____/____

(First, Middle Initial and Last)

Primary reason for visit: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Has your insurance changed since your last visit? ☐ **Yes** ☐ **No**

Has your contact information changed since your last visit? ☐ **Yes** ☐ **No**

Mailing Address: _____

City: _____State: _____ Zip: _____ Tel: (_____) _____-_____

Email Address: _____

IPM will bill Medicare PPO for covered services until December 31, 2018. Beginning January 1, 2019, IPM will no longer accept Medicare PPO and cannot bill Medicare for services. IPM does not accept HMO, EPO, MediCal or other PPO insurance for office visits and procedures. We currently accept major credit cards, cash, personal check and CareCredit as forms of payment. Payment is due at the time of service.

Who may we contact in the case of an emergency?

Name: _____Relationship:_____Tel:(_____)_____-_____

	Current Medications Name	**Strength and Dosage**	**How often per day_**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Drug Allergies (please mark appropriate):

☐ No Reactions ☐ Penicillin Reaction ☐ Codeine Reaction ☐ Sulfa Reaction ☐ Other Reactions_____

Smoking and Alcohol History:

Do you smoke now? ☐ Yes ☐ No For how many years did you smoke? _____

Have you smoked in the past? ☐ Yes ☐ No When did you quit? _____

Do you use other tobacco products? ☐ Yes ☐ No Specify:_____

How much alcohol do you drink: ☐ None ☐ 1-7 Drinks/week ☐ 8-14 Drinks/week ☐ Specify: _____

MY SIGNATURE BELOW CONSTITUTES CONSENT TO MEDICAL SERVICES

I consent to medical evaluation and treatment by The Institute for Progressive Medicine. I understand that Institute for Progressive Medicine doctors and staff may recommend various methods to help me regain my health and those methods will be discussed. I understand that alternative therapies may also be recommended and choosing to receive any course of treatment will be always be my decision as the patient.

_____

Patient Name (please print) **Patient Signature** **Date**