Medical History Form

Patient Name: _____ DOB: _____ Sex: ❑F ❑ M

Hand Dominance: ❑ R ❑L Height (feet, inches): _____ Weight (lbs.) _____

Reason for visit: _____

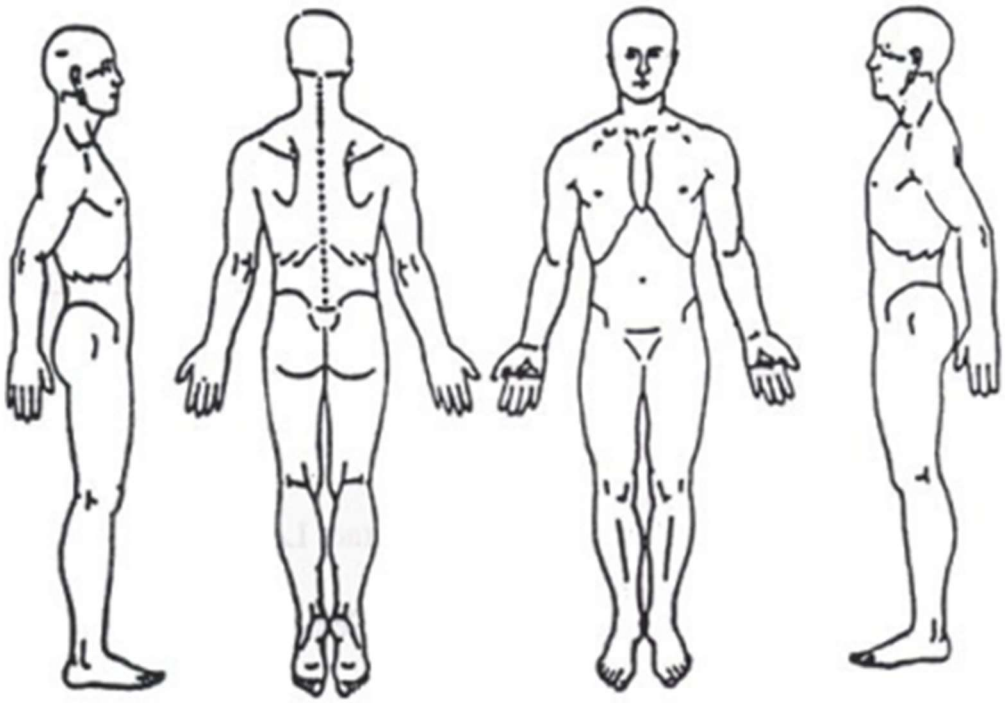
Describe how your illness or pain began, include date(s) if known:

_____

Please use the key symbols to mark where you feel that type of sensation on the body:

Key:

===	numbness
^^^	ache
000	pins and needles
///	stabbing
XXX	burning
---	shooting
***	tingling



Is there anything that makes your pain/symptoms WORSE?	Is there anything that makes your pain/symptoms BETTER?

Check box (X) that describes:	0 None	1-2 Mild	3-4 Uncomfortable	5-6 Distressing (fairly severe)	7-8 Very Severe (horrible)	9-10 Unbearable (excruciating)
Pain as it usually feels	❑	❑	❑	❑	❑	❑
Pain at its worse	❑	❑	❑	❑	❑	❑
Pain at its least or no pain	❑	❑	❑	❑	❑	❑

How many days a week do you experience pain? ❑ Daily ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ Intermittent

Medical History Form

Regenexx® Des Moines

Have you had any of the following treatments or testing for your conditions? (Check all that apply)	
❑ Surgery Date(s)?	❑ Injections: -Date or last injection? -What was injected?
❑ Chiropractic or Osteopathic Adjustments	❑ Physical Therapy
❑ Acupuncture	❑ Massage
❑ Prescription Medication	❑ OTC Medication (e.g., ibuprofen, acetaminophen)
❑ X-ray	❑ MRI
❑ Ultrasound	❑ CT
❑ EMG/NCV	❑ Other:

In the *past month*, have you had any of the following problems?

GENERAL
- ❑ Unplanned weight change
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Loss of Motion
- ❑ Stiffness

ENT
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Difficulty swallowing
- ❑ Pain in jaw
- ❑ Sore throat

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss
- ❑ Seizures
- ❑ Paralysis

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Persistent diarrhea
- ❑ Black or bloody stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Bruising
- ❑ Bleeding
- ❑ Clots

EYES
- ❑ Blurred vision
- ❑ Loss of vision
- ❑ Double vision

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine
- ❑ Incontinence
- ❑ Urgency

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Change in sleep pattern
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Hallucinations
- ❑ Nervousness
- ❑ Mood swings
- ❑ Anxiety

OTHER PROBLEMS:

_____

_____

Family History			
	❑ Arthritis (any type)	❑ Cancer	❑ Diabetes
	❑ Heart Problems	❑ Osteoporosis	❑ Stroke
	❑ No family history of medical problems	❑ Other:	

Medical History Form

Pharmacy Information
Pharmacy Name:
Pharmacy Address:
Pharmacy Phone #:

Allergies: List all medication, environmental, food, or chemical allergies and type of reaction ❑ No allergies

Prescription Medications: ❑ None

Over the Counter Medications, Supplements, Vitamins, Creams, Eye Drops, Oils, or Others ❑ None

PAST MEDICAL HISTORY Do you now or have you ever had:			❑ None
❑ Anemia	❑ Deep Vein Thrombosis	❑ Heart Murmur	❑ Pulmonary Hypertension
❑ Arthritis (Rheumatoid/Osteoarthritis)	❑ Diabetes	❑ Hepatitis	❑ Seizures
❑ Asthma	❑ Folic Acid Deficiency	❑ High Blood Pressure	❑ Sleep Apnea
❑ Bleeding Disorder	❑ Gout	❑ HIV/AIDS	❑ Stroke
❑ Cancer	❑ Heart Attack	❑ Low Platelet Count	❑ Thyroid Disease
❑ COPD	❑ Heart Arrhythmia	❑ Osteoporosis/Osteopenia	❑ Vitamin B12 Deficiency
❑ Other (Please list)			

Medical History Form

Injuries: Automobile accident, fractures, strains, sprains, concussion, any other ❑ No injuries

_____

_____

Surgeries: Please include dates ❑ No surgeries

_____

_____

Have you had any adverse reactions to local anesthetics? (e.g., Novocain, lidocaine)

❑ Yes ❑ No ❑ Unknown What was your reaction? _____

Have you had any adverse reactions to sedation?

❑ Yes ❑ No ❑ Unknown What was your reaction? _____

Do you have any implanted medical devices or prosthetics?

Yes ❑ No *If yes, please provide a copy of your* ***"Medical Identification Card"*** *or provide the following information*:

Device Name or Type: _____ Manufacturer: _____

Model Number: _____ Implantation Date: _____

Social History	Occupation:		
	Marital Status:	❑ Single ❑Married ❑ Divorced ❑ Widowed ❑ Other	
	Do you exercise?	❑ Yes ❑ No	If yes, what type and how often?
	Do you us tobacco?	❑ Yes ❑ No	If yes, how often?
	Do you use alcohol?	❑ Yes ❑ No	If yes, how often?
	Do you use recreational drugs?	❑ Yes ❑ No	If yes, how often?
	What are your interests or hobbies?		

Regenexx® Des Moines

PLEASE ARRIVE 30 MINUTES BEFORE YOUR APPOINTMENT

PATIENT DEMOGRAPHIC FORM

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Preferred Phone: _____ ❑ Home ❑ Cell ❑ Work May we leave a message? ❑ Yes ❑ No

Secondary Phone (if applicable): _____ May we leave a message? ❑ Yes ❑ No

Email: _____ Ethnicity: ❑ Decline ❑ Hispanic or Latino ❑ Not Hispanic Latino

Race: ❑ Decline ❑ African American or Black ❑ American Indian or Alaskan Native ❑ Asian

❑ Native Hawaiian or Other Pacific Islander ❑ White ❑Other

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed

Primary Doctor: _____ Primary Doctor Phone: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Pharmacy Phone: _____

Primary Insurance: _____ Subscriber/Policy ID Number: _____

Group Number: _____ Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

If Different Than Patient; Policy Holder's Name: _____ DOB: _____

Do You Have Secondary Insurance? ❑ Yes ❑ No

Please provide insurance card(s) at the time of your appointment.

Emergency Contact: _____ Relationship: _____

Phone: _____ ❑ Home ❑ Cell ❑ Work May we leave a message? ❑ Yes ❑ No

Alternate Phone: _____ ❑ Home ❑ Cell ❑ Work

May we discuss protected health information with this contact? ❑ Yes ❑ No

If you have an Advanced Directive or a Durable Power of Attorney for Healthcare and you wish for these documents to be honored as part of your care, please provide copies to us.

PATIENT RECORD OF DISCLOSURES & COORDINATION OF CARE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

It is company policy not to have recorded evaluations. We encourage the patient to take notes. Upon request, the company can provide a copy of the Doctor's evaluation.

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

❑ Yes ❑ No If Yes, person's name: _____ Phone: _____

Relationship: _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- Telephone Communication
  - ❑ Home telephone
    - ❑ Okay to leave a message
  - ❑Work telephone
    - ❑ Okay to leave a message
  - ❑Mobile telephone
    - ❑ Okay to leave a message
- Written Communication
  - ❑ Okay to mail home address
  - ❑ Okay to mail work address

❑Okay to leave information with specified people. (Primary care physician, spouse, attorney, friend, etc)

Please include name, relationship, and phone number:

_____

_____

_____

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

____Regenexx Des Moines is committed to providing excellent, personalized patient care. To do so, we understand that you may need to email and/or text your provider during your treatment. Communication through email and/or text is not encrypted and may pose a HIPAA risk if sensitive information is communicated, and a breech were to occur. By initialing, you agree that if you use electronic communication with your provider, you are assuming this unlikely risk.

FINANCIAL POLICY

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral or prior approval, I must obtain it prior to my visit.
- If, in the event that, my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Regenexx Des Moines on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Regenexx Des Moines to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical provider.

4. **MEDICARE REQUEST FOR PAYMENT**

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Regenexx Des Moines. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

5. **NON-PAYMENT ON ACCOUNT**

Payment is due the day of treatment or within 10 days of receipt of your billing statement. Any balance over 90 days will be referred to a collection agency and the balance not paid will begin to accrue interest at the rate of 1.5%/month or the maximum allowed by law, whichever is lower. In addition, you agree you will be responsible for all costs of collection – late fees, charges, interest, court costs, collection fees, legal and other costs of collection.

I have read the *Financial Policy*. I understand and agree to the *Financial Policy*. I acknowledge that a copy of Regenexx Des Moines' *HIPAA Notice of Privacy Practices was made available*.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

A copy of this signed, dated document shall be effective as the original.

The next three pages are your copy of our privacy practices.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Release TO: _____ Release FROM: _____

Address: _____ Address: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Specifically, I Request for The Following to Be Sent:

- ❑Radiology Report(s) and Imaging
- ❑Physician's Reports
- ❑Complete Records

This authorization is indefinite until revoked. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that I may have a right to inspect disclosed information at any time and that such an inspection will occur in a meeting with a member of the professional staff.

PROHIBITION ON REDISCLOSURE: This form does not authorize redisclosure of Medical Information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for substance abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa code Ch. 22) prohibits further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and or regulations. A general authorization for the release of Medical or other Information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of substance abuse or mental health information.

_____ _____

Signature of Patient or Patient's Authorized Representative Date Signed

OFFICE USE ONLY

Sent Via: Fax Mail Sec. Email

Date Sent: _____ Staff Initials: ____

Regenexx™
The Trusted Alternative to Orthopedic Surgery

PATIENT CONSENT FORM FOR HEIDI AI CLINICAL DOCUMENTATION ASSISTANT

Purpose of this Consent Form

This form requests your consent for Dr. Russell Bergum to use Heidi AI, an artificial intelligence clinical documentation assistant, during your medical consultation. Heidi AI helps create accurate clinical documentation by recording and transcribing your conversation with Dr. Bergum. This allows Dr Bergum to focus on you during your visit, and not on entering information into your chart.

How Heidi AI Works

1. Your consultation with Dr. Bergum will be audio recorded
2. The recording is transcribed into text using secure technology
3. The transcription helps generate clinical documentation
4. The audio recording is permanently deleted immediately after transcription is complete
5. Dr. Bergum reviews the clinic note generated and makes any necessary edits prior to saving it to your medical record

Data Security and Privacy Protections

Heidi AI maintains the highest standards of data security and privacy:

- **HIPAA Compliant**: Fully compliant with the Health Insurance Portability and Accountability Act
- **SOC 2 Type II Certified**: Meets rigorous standards for security, availability, and confidentiality
- **HITRUST CSF Certified**: Adheres to comprehensive security framework for protecting sensitive information
- **End-to-End Encryption**: All data is encrypted during transmission and storage
- **Zero Data Retention**: Audio recordings are permanently deleted after transcription
- **No Third-Party Sharing**: Your information is never shared with third parties

Your Rights

- Your participation is voluntary
- You may withdraw consent at any time
- You may request information about how your data is processed
- You have the right to access your medical records

Consent Statement

I understand that Dr. Russell Bergum will use Heidi AI to assist with clinical documentation during my consultation. I understand that my consultation will be audio recorded, the recording will be used solely for the purpose of creating clinical documentation, and the recording will be permanently deleted immediately after transcription is complete.

I acknowledge that Heidi AI employs industry-leading security measures to protect my personal health information and does not share my information with third parties.

Patient Name: _____

Patient Signature: _____

Date: _____