

-Registration Form-& Acknowledgements

(please print)

Date ____/____/____

-Patient Information-

Name _____ SS # _____
Last Name First Name Middle Initial

Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Sex: M ___ F ___ Age _____ Birthdate ____/____/____ Married ___ Widowed ___ Single ___ Minor ___
Separated ___ Divorced ___ Partnered for ___ years

Email: _____

Patient Employer/School _____ Occupation _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone: _____ - _____ - _____

Pharmacy Name: _____ Phone Number: _____ - _____ - _____

-Primary Insurance-See Card

-Additional Insurance-See Card

-Assignment and Release-

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign

Name of Insurance Company

directly to Eagle's Landing Longevity Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Eagle's Landing Longevity Center may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Parent, Guardian or Personal Representative Relationship to Patient

Privacy Practices

I _____, certify that I have read and understand Eagle's Landing Longevity Center Privacy Practices.

Patient or Legal Authorized Signature Date

Relation to patient if anyone other than patient: _____

Financial Policy

My signature below indicates that I have read, understand and accept full responsibility for the balance on my account for any services provided by Eagle's Landing Longevity Center.

Signature: _____ Date: ____/____/____

Print Name: _____ SS: _____ - _____ - _____

Eagle's Landing Longevity Center
Privacy Practices

I understand that Eagle's Landing Longevity Center may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Eagle's Landing Longevity Center has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting a patient's privacy. I understand I have the right to read the Notice of Privacy Practices before signing this acknowledgement.

Eagle's Landing Longevity Center may update this Acknowledgement and Notice of Privacy Practices. If I ask, Eagle's Landing Longevity Center will provide me with the most current Notice of Privacy Practices.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Eagle's Landing Longevity Center has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies of non-routine information needs; etc. I will assist by following these procedures if I choose to exercise any of my rights described in the Notice of privacy Practices.

Financial Policy

Thank you for selecting Eagle's Landing Longevity Center for you healthcare needs. In order to prevent any misunderstanding concerning the responsibility of payment for medical care and laboratory fees, the following information is provided:

HMO / PPO / Other Insurance Coverage

All co-payments are collected prior to the office visit. Failure to provide all necessary information may result in the patient's responsibility to pay for services in full on the date of the office visit or laboratory service. Patients will be financially responsible for all co-payments, deductibles, co-insurance, non-covered services, and other amounts identified by the insurance company as due from patient.

Medicare

Eagle's Landing Longevity Center accepts Medicare assignment. Patients are responsible for the deductible, 20% coinsurance, and all noncovered services. If you have secondary insurance, please provide us with that information so that we can submit a claim on your behalf. Please keep in mind that Medicare does not cover preventive care. You will be responsible for annual exams and other preventive services.

Laboratory

Depending on your insurance plan, you may be responsible to pay an additional co-payment for specimen taken during your office visit.

Self-Pay Patients

Patients without health insurance and patients who do not wish for Eagle's Landing Longevity Center to bill their insurance company are required to pay for the services in full on the date of service.

Payments

Payments can be made by cash, check, Care Credit, Visa, Master Card, and Discover.

Returned Checks and Collections

A charge of \$25 will be added to a patient's account for all refunded checks. In the event that any action is brought to collection, patient is required to pay any reasonable collection costs and/or attorney fees.

No Show / Missed Appointments

A Charge of \$30.00 will be added to patient's account when they do not show up for a scheduled appointment or fail to give a minimum 24 - hour cancellation notice. Any patient who has multiple missed appointments or who repeatedly does not give proper cancellation notice may be dismissed from the practice.

Eagle's Landing Longevity Center
Medical History Form

NAME: _____ DATE: _____

DOB: _____ AGE: _____ WEIGHT: _____ HEIGHT: _____ OCCUPATION: _____

Reason for office visit:

Date Began:

Drug Allergies

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

Transfusions – Date (year) _____ Most Recent: _____

Father's Age and Health _____

Mother's Age and Health _____

Brothers/Sisters Age and Health _____

Children _____

Any Family History {blood relative} who has had:

Diabetes _____

Elevated Blood Pressure _____

Heart Disease _____

Cancer _____

Do you smoke?	Yes or No	How Much?	_____
Do you drink alcohol?	Yes or No	How Much?	_____
Do you drink tea?	Yes or No	How Much?	_____
Do you drink coffee?	Yes or No	How Much?	_____

Date of last physical exam: _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): _____

Outcome: _____

List current health problems for which you are being treated _____

Current Medications (prescription or over-the-counter) _____

Major hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Do you experience any of these general symptoms EVERY DAY? (please circle)

Debilitating Fatigue Shortness of Breath Insomnia Constipation Chronic Pain/Inflammation Depression Panic Attacks
Nausea Fecal Incontinence Bleeding Disinterest in sex Headaches Vomiting Urinary Incontinence Discharge Disinterest in eating
Disinterest in eating Dizziness Diarrhea Low grade fever Itching

BHRT CHECKLIST FOR WOMEN

Name: _____

Date: _____

E-Mail: _____

DOB _____

Age: _____

<u>Symptom (please check mark)</u>	<u>Never</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
Depressive mood (feeling down/sad/lack of drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory Loss (forgetfulness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental confusion (feeling in a mental fog)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sex drive/libido (decreased desire for sex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems (difficulty falling/staying asleep/wake up tired)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood changes/Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine/severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult to climax sexually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry and Wrinkled Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair is Falling Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold all the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling all over the body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family History: *Circle all that Apply*

Heart Disease Diabetes Osteoporosis Alzheimers Disease Breast Cancer

Medical History: *Circle all that apply*

On Birth Control _____ Still Menstrating Experiencing Symptoms Currently Pregnant
 On HRT (Type/Dose) _____ Hashimoto's
 Currently of Thyroid Medication (Type/Dose) _____ History of Breast Cancer
 Hysterectomy Fibrocystic Breast Disease PCOS
 History of Uterine Fibroids or Endometria Polys Smoker

Symptoms: *Circle all that apply*

Acne Breast Tenderness
 Facial Hair PreMenstrual Migraines

Weight: _____

Ethnicity: _____

BHRT CHECKLIST FOR MEN

BHRT CHECKLIST FOR MEN

Date: _____

E-mail: _____

DOB: _____

Age: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Decline in general well being (General state of health)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain/muscle ache (Lower back/joint/limb pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive sweating (Sudden episodes/hot flash)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems (Difficulty falling/staying asleep/wake up tired)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased need for sleep (Feel tired often)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (Aggressive/easily upset/moody)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness (Inner tension/restlessness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (Feeling panicky)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed mood (Feeling down/sad/lack of drive/nothing of any use)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhaustion/lacking vitality (Decreased performance & activity/lack of interest/motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Declining Mental Ability/Focus/Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling you have passed your peak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling burned out/hit rock bottom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased muscle strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain/Belly Fat/Inability to Lose Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shrinking Testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in beard growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased desire/libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased morning erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased ability to perform sexually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infrequent or Absent Ejaculations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Results from E.D. Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family History: Circle all that Apply

Heart Disease Diabetes Osteoporosis Alzheimers Disease

Medical History: Circle all that Apply

Altitude (above 5,000 ft) Hashimoto's Prostate Cancer _____ On 5a Reductase
 Urological WorkUp Performed & OK Currently on Thyroid Medication (Type/Dose) _____

Activity Level: Low Moderate Medium High High **Weight:** _____ **Ethnicity:** _____

Allergy Questionnaire

Patient Name: _____
 Phone Number: _____ - _____ - _____

DOB: ____/____/____
 Date: ____/____/____

Do you experience any of the following symptoms?	Frequency		
	Daily, Weekly, Monthly, Seasonally, Year round		
	Yes	No	
Runny/Stuffy nose, Frequent Sneezing,			
Post nasal drip			
Itchy/Dry/Watery eyes			
Itchy/Dry mouth, throat, or ears			
Frequent cough or Frequent colds			
Seasonal allergies			
Sinus problems			
Food allergies			
Restless, Poor sleep or snoring			
Fatigue or irritability due to restlessness or			
Poor sleep			
Have you ever been told you have Asthma, RAD or			
Eczema?			
Have you ever used Albuterol?			
Have you ever been to an Allergist?			
Does your family have a history of Allergies?			
Do you think you might be allergic to animals?			

What medicines have you used to control your symptoms in the past year? (Please check)

Over-The-Counter Medications

a. Allergy/Cold Medications

- ___ Claritin, Alavert, Zyrtec or Allegra
- ___ Benedryl or Sudafed
- ___ Cough, Cold or Sinus Medication

b. Over-The-Counter Nasal Sprays

- ___ Nasal Saline, Nasal Washes or Neti-Pot

c. Over-The-Counter Nasal Decongestants allergies

- ___ Afrin or Neosynephrine

Prescription Medicines

d. Oral Allergy Medications

- ___ Claritin, Zyzol, Singular

e. Nasal Steroids/Antihistamines

- ___ Flonase, Nasonex, Rhinocort, Nasacort
- ___ Astelin, Veramyst, Pantanase

Have you been previously tested for allergies

- ___ Yes ___ No

List any allergy medications you have tried _____

Above information reviewed and discussed with the patient

- ___ Yes ___ No

I will refer this patient out for In-House Allergy testing

- ___ Yes ___ No

Provider: _____

Sylvain Longevity Center
Vein Patient History Information

Please fill out page as completely as possible:

Patient Name _____ Date: _____

Age: _____ Male: _____ Female: _____ Occupation: _____

Were you referred by a physician? Yes _____ No _____

If yes, M.D. name: _____ Specialty: _____

What made you decide to seek treatment at this time? _____

Symptoms (please check all that apply)

Check if true:

Aching/Pain in leg.....Left ___ Right ___
 Heaviness..... Left ___ Right ___
 Tiredness/Fatigue..... Left ___ Right ___
 Itching/Burning.....Left ___ Right ___
 Swelling Left ___ Right ___
 Leg crampsLeft ___ Right ___
 ThrobbingLeft ___ Right ___

_____ My veins have deteriorated in recent months.
 _____ I elevate my legs to relieve discomfort.
 _____ I wear support hose. Type of support hose: _____
 _____ These are prescription hose. They help reduce symptoms. _____
 _____ Standing makes my symptoms worse.
 _____ I stand _____ hours daily.
 _____ I smoke _____ packs per day.
 _____ I am able to walk 3 miles daily.

Additional Comments:

Women only:

_____ My symptoms are worse before or during menstruation.
 _____ I am pregnant or actively trying to become pregnant.
 _____ I am breast feeding.

Medications: please list all medications, hormones, birth control pills, or supplements you are currently taking by Prescription or over the counter: _____

Allergies: Please list all allergies to medicines, iodine, IVP dye, foods, or other substances and the type of reaction you have. (e.g. hives, rash, trouble breathing, etc.)

Medical History: Please check all boxes that are true and give descriptions where appropriate.

History of: Vein Surgery Type & Date: _____

Vein injections _____

Blood clots (Phlebitis) _____

___ Previous Vein Evaluations
 ___ Leg Ulcer
 ___ Heart Disease
 ___ HIV (AIDS)
 ___ Other Surgeries

___ Leg Swelling
 ___ Leg injury
 ___ High Blood Pressure
 ___ Diabetes
 ___ Hospitalizations

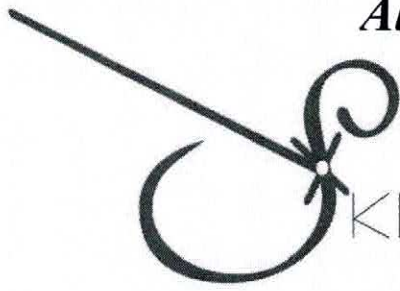
___ Pregnancies Number ___
 ___ Deliveries Number ___
 ___ Hepatitis
 ___ Other _____

Family History Of:

___ Varicose Veins
 ___ Heart Disease

___ Leg Ulcers
 ___ Other (Diabetes or Vascular Disease)

Also introducing....



Eagle's Landing
KIN ENHANCEMENT
& VEIN CENTER
- where your inner beauty surfaces -

(Conveniently located downstairs)

Established in 2001, **Eagle's Landing Skin Enhancement & Vein Center** along with Dr. Gayla Sylvain skillfully combine the latest, most effective technologies and NON-SURGICAL treatments. We also have a wide variety of physician approved medical anti-aging skincare products to enhance and promote a healthier, youthful appearance.

Below you will see our services that help you look and feel good about your appearance:

Botox (for expression lines around the forehead and eyes)

Fillers (for fine lines and wrinkles)

Laser Hair Removal

CoolSculpting (permanent fat reduction)

Skin Tightening

Microdermabrasions (exfoliate your skin with micro fine crystals)

Chemical Peels (exfoliate your skin with glycolic and/or salicylic acid)

HydraFacials (extract, hydrate, exfoliate, detoxify and rejuvenate your skin)

Hair Restoration (for hair loss)

Fotofacial IPL (for rosacea, sun damage and uneven skin tones)

Cosmetic Vein Treatments (After medical evaluation)

(Please Circle YES or NO)

Would you like a representative from Eagle's Landing Skin Enhancement contact you for your COMPLIMENTARY consultation? YES NO

Name _____

Phone _____

Email _____