Beyer Regenerative Medicine Institute

Regenerate, Rejuvenate, Restore.
17023 S. Harlem Ave Tinley Park
Phone Number: 708-614-1222
Dr. Edward J. Beyer

CONFIDENTIAL PATIENT INFORMATION

Are you primarily here for: ☐ Stem Cell Injections ☐ Hyaluronic Acid Gel Injections ☐ Both

Date:____________________________ Email Address:__________________________________

Full Name: ____

Name of Wife, Husband or Guardian: ____

Address:____

City: _____________________________________ State: _______________ Zip Code: ________

Telephone Number: (   )________________ Cell Phone Number: (   )____________________

Birth Date: _____________ Male:________ Female: ________ Marital Status: S__M__D__W__

Weight:________ Height:________ Number of Children:________ Currently Pregnant?________

Occupation: ______________________Employer's Name/Phone:________________________

Spouse's Occupation/Employer: ____

Name and Phone Number of Emergency Contact: _______________________________________

How did you hear about our office? (Please Circle):

-Facebook Ad -Google Search -Commercial -Mailer -Referral -Webinar/Seminar

Appointment Reminders? ___ Voice Home ___ Voice Cell ___ Text ___ Email ___ None

Primary Complaint(s) ____

When Symptoms Started ___/___/___/ How Symptoms Started ______________________________

Please rate your pain from 0-10 (0= no pain; 10=extreme pain):

Body Part: _____________ Pain: 0 1 2 3 4 5 6 7 8 9 10

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What is your pain/condition holding you back from doing (ie. Sleeping, exercising, traveling, time with family, hobbies, eating healthy, etc.)? ____
What makes your problem better? ____
What makes your problem worse? ____
Have you had any surgeries on your area of complaint? : ______________________________________

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List ALL medications and supplements you take. (Prescription and over-the-counter, use additional paper if needed)

Drug Name:	Dosage:	How long have you taken and for what conditions?
____________________	_____________	____
____________________	_____________	____
____________________	_____________	____
____________________	_____________	____

Check ALL (symptoms/pain) you may have had or do have now:

___Depression	___Hepatitis	___Diabetes	___Lupus
___Asthma	___Fibromyalgia	___Irritable Bowel	___Emphysema
___Back Pain	___Cancer	___Stroke	___Heart Attack
___Thyroid Problems	___Chronic Fatigue	___Heart Disease	___Eczema
___Ulcers	___Constipation	___Diarrhea	
___High/Low Blood Sugar	___Rheumatoid Arthritis	___High Blood Pressure	

Do you consume any of the following? (Leave blank what does not apply)

Tobacco Products (packs/day) _____________

Alcohol drinks/week _____________

AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPAA Privacy Regulations.

May we leave a message for you on your answering device? Yes _____________ No _____________

I fully understand that my signature is consent and authorization to be examined by Dr. Edward Beyer.

Patient Signature ______________________________________ Date: _____________________________