

 **PATIENT REGISTRATION FORM**

  Mr.  Mrs.  Miss  Ms  Dr.  Pastor  Captain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name MI Last Name

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **** Male  Female

Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Perferred Contact: ** Home  Work  Mobile**

I authorize Cobb Eye Center to communicate my protected health information to me with a

detailed message via the following methods:  Voicemail (home or Mobile#)  Email

 I do NOT authorize Cobb Eye Center to leave detailed messages on voicemail or email.

I agree to receive text messages to the above mentioned mobile number reminding me about my

upcoming appointments. I understand that SMS reminders are optional and that message & data

rates may apply.  Yes  No

**Emergency Contact Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name Last Name

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Designated HIPAA Release & Communication**

At my request, I authorize Cobb Eye Center to disclose my protected health information to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Insurance Information**

Insured Party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Same as Patient

 First Last

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_\_\_ Home# : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship To Insured:  Self  Child  Spouse  Other Gender:  Male  Female

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby affirm that a copy of the Notice of Privacy Practices from

**Cobb Eye Center** has been presented to me and a copy is available upon request. Under federal law 104-191, known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider.

My signature below also affirms the information I have provided is factual and accurate. My signature also signifies that I have been presented with a copy of the Notice of Privacy Practices but does not legally bind or obligate me in any way.

I voluntarily consent to evaluation and treatment from the physicians and staff at Cobb Eye Center. I am aware

that the practice of medicine is not an exact science and no guarantees have been made regarding the results of treatment or examinations by Cobb Eye Center. I consent to the use and disclosure of protected health information about me for treatment, payment and operations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Date Name of Patient or Legal Guardian

 **Patient Financial Responsibility Agreement**

In order for us to provide our patients with quality medical care, we must receive payment for our services.

This document explains the patient’s obligations in regards to financial responsibility for services rendered.

In exchange for services rendered, each patient or patient’s guarantor agrees to:

* Authorize payment of surgical and medical benefits to Cobb Eye Center (CEC) which would

 otherwise be payable to you. If covered by Medicare or Medicaid, I certify that the information

 provided by me in applying for payment and titles V, XVII, and/or XIX of the Social Security Act is

 correct.

* Pay all non-covered charges (including refraction), co-pays, co-insurance, deductible, and out-of -network charges at the time of service.
* Refraction Fee: $40.00.
* Cancellation Fee: $40.00 Applied for failure to provide a 24 hour cancellation notice
* Contact Lens Fitting Fee: This fee varies depending on the type of contact lens you request or

 the type of lenses necessary to provide you the best possible vision. The fee is collected in

 addition to the fee for an eye examination.

* Provide a copy of your most recent insurance card, other proof of insurance and/or register with the

 receptionist at the time of EACH visit. If you do not provide us with valid insurance information at the

 time of EACH visit, and your insurance company subsequently denies our claim, you will be responsible

 for any and all charges.

* Obtain any authorization or referral required by your insurance plan and/or from your Primary Care

 Physician prior to each appointment. If you do not receive the required authorization and insurance

 does not pay for services rendered, you will be responsible for any and all charges. Additionally, we

 may need to reschedule your visit if you do not have your authorization or referral.

In the event we must refer the patient’s account to a collection agency or attorney for collection of an amount

90 days or older, the patient and/or guarantor agrees to pay our collection fee, including any accrued interest

and all applicable bank fees incurred for a returned check.

As the patient or guarantor of a patient, I agree that in consideration of the services rendered by CEC, I am

individually obligated to pay for all services in accordance with the regular rates, terms and conditions of CEC.

As a courtesy to our self-pay patients seeking routine eye care, CEC will provide a reduced charge if services

are paid in full at time of rendering. Once you accept the discount, we will not be responsible for filing claims

to any insurance company nor will we accept payment from any insurance company. In the event we receive

an insurance payment under these circumstances, we will refund the money to the insurance company.

I have read this form and have had the opportunity to ask questions and my questions have been answered.

By my signature, I represent that I have voluntarily read, understand and agree to be bound by the above

provisions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guarantor Signature Date

 **MEDICAL INFORMATION REVIEW**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Endocrinologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rheumatologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardiologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Medical History:

Do you have or have previously been treated for (if so, please describe):

Y/N Cataract \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Macular Degeneration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Eye Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Dry Eye \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Diabetes: \_\_\_\_\_\_\_\_\_ years

 Controlled by Diet/Pills/Insulin (circle)

Y/N High Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Heart Attack/Heart Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Kidney Disease/Dialysis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Thyroid Disease:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Stroke: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_

Y/N Cornea Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Retinal Tear/Detachment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Diabetic Eye Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Crossed Eyes/Lazy Eye \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N HIV/AIDS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Abnormal bleeding: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Arthritis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N High Cholesterol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Lung Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Are you pregnant/breastfeeding? Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Eye Surgeries (Please list with dates, doctor)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Other Surgeries (Please list with dates, doctor)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Eye Medications (Prescription and over the counter, include dosage and frequency)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Other Medications (Prescription and over the counter, include dosage and frequency)

 (If you have a list to provide please give it to the front office staff)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Are you allergic to any medications? If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your **family** had any of the following? If yes, please list relationship.

Y/N Cataract\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Macular Degeneration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Corneal Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Retinal Tear/Detachment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Crossed Eyes/Lazy Eye \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Y/N Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Health History**

**Social History**

Y/N Smoker Y/N Do you drive Y/N Do you have a CDL license?

 Former, Every day, Never (Circle) Y/N Fall Risk

Y/N Alcohol If yes, please list last fall date \_\_\_\_\_\_\_\_\_\_\_\_\_

 Former, Every day, Social, Never (Circle)

**Review of Systems**

|  |  |  |  |
| --- | --- | --- | --- |
| Are you currently experiencing any problems: | YES | NO | Details (please list below) |
| Allergy/Immunology*Autoimmune, Itching, Rash, Redness, Sjogren’s Disease, Other* |  |  |  |
| Cardiovascular*Chest pain, Shortness of breath, CHF, Palpitations, Other* |  |  |  |
| Constitutional*Fever, Fatigue, Chills, Loss of Appetite, Night Sweats, Other* |  |  |  |
| Endocrine*Excessive urination, Dry skin, Insomnia, Other* |  |  |  |
| Gastrointestinal*Nausea, Diarrhea, Trouble swallowing, Jaundice, GERD, Other* |  |  |  |
| Genitourinary*Dialysis, Genital sores or ulcers, Kidney failure, Incontinence, Other* |  |  |  |
| Hematology/Oncology*Easy bruising, Hepatitis, HIV, Anemia, Blood thinners, Frequent or easy bleeding, Other* |  |  |  |
| HENT (Ear, Nose, Throat)*Hearing loss, Has a cold, Hearing aids, Other* |  |  |  |
| Integumentary (Skin)*Changes in mole, Bruises, Growths, Psoriasis, Rosacea, Rash, Other* |  |  |  |
| Musculoskeletal*Joint pain, Difficulty laying flat, Swelling, Bone fracture, Other* |  |  |  |
| Neurologic*Scalp tenderness, Dizziness, Tremor, Seizures/Fainting, Parkinson’s, Speech problems, Alzheimer’s, Dementia, Developmental delayed, Migraine, MS, Other* |  |  |  |
| Psychiatric*ADHD, Bipolar, Loss of memory, Anxiety, Confusion, Other* |  |  |  |
| Respiratory*Cough, Bronchitis, Use of oxygen, Sleep apnea, Other* |  |  |  |