Utah Stem Cells
Joint Treatment & Wellness Center

6699 S 1300 E Ste 150
SLC UT 84121
801-999-4860
801-878-9717

NEW PATIENT INFORMATION

Name: _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____ Gender: ☐M ☐F Marital Status: ☐M ☐S ☐W ☐D

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Primary Care Physician: _____

E-mail: _____ May we contact you for reminders and/or promotions? ☐Y / ☐N

How did you hear about us? (Please Select): ☐TV commercial (channel _____) ☐TV talk show (channel _____)

☐Radio ☐Google ☐Newspaper ☐Friend/Family _____

Driver's License: _____ SS: _____

Whom may we contact to speak regarding your care: _____ Phone: _____

SPOUSE/ GUARDIAN

Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Cell Phone: _____

Notice of Privacy Practices:
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic , including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatments received.

Non-Covered Service Policy:
Certain services performed by our office are NOT covered by insurance plans. Some of these services include Bio-identical Hormone Replacement Therapy (BHRT), Stem Cell &PRP injections, skin care facials, chemical peels, micro-needling, Botox and other fillers, medical weight loss, and other cosmetic and/or investigational (as determined by the AMA) procedures. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice (ABN) for non-covered services.

Patient Signature: _____ Date: ____/____/____

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