Lifespan The Center for Anti-Aging & Regenerative Medicine

Daniel Goodman MD
(530)605-4557
1832 Buenaventura Blvd, Suite B Redding, CA 96001

# New Patient Form

Name: _____

D.O.B. _____ ID / Drivers License # _____

E-mail Address: _____

Mobile Phone: _____Home Ph:_____ Work Ph:_____

Home Address: _____

Spouse Name:_____Phone:_____

Emergency Contact: _____Phone:_____

Primary Health Care Provider Name: _____

Primary Health Care Provider Pracitce:_____

Can we contact above health care provider? .....Yes ☐ No ☐

Do you use flouride toothpaste?.....Yes ☐ No ☐

Do you use mouthwash?.....Yes ☐ No ☐

Gender: _____Current Weight: _____ Height: _____

Chief Concern(s):

Allergies:

Current Medication and Dosages:

Current Supplements and Dosages:

Physical History: Any Health(s) issues with any listed below?

Heart / Lung:

Liver / Kidney / Diabetes:

Cancer:

Autoimmune Disease:

Please list any medical history not listed above:

Please list any surgical procedures including dates:

Please add any additional information on the 3rd page.

**Female Patients:**

Are you still having menstrual cycles?.....Yes ☐ No ☐

Are your cycles regular?.....Yes ☐ No ☐

Date of last menstrual cycle: _____

Do you have troublesome PMS symptoms .....Yes ☐ No ☐

If Yes please describe type and duration:

How did you hear about our practice?: _____

_____ _____

Patient Signature Date

Additional Notes: