

Serenity



Health & Wellness Center
1685 Lance Pointe Drive, Maumee, 43537
(419) 891-2181
www.SerenityHealthMaumee.com

Patient Information (please print)

Patient Name: _____ Home Phone: (_____) _____

Address: _____

Date of Birth: _____ City _____ State _____ Zip _____
Sex (please check) Male _____ Female _____

Email Address _____

Cell Phone: _____ Work Phone: (_____) _____

Service(s) receiving today: _____

Time of Appointment: _____

Physician

Referring Physician _____ Primary Care Physician _____

Symptom/Treatment Information (Mandatory)

Do you have any diagnosed medical condition(s): _____

If yes, please explain: _____

Are you currently experiencing any physical pain or discomfort? _____

If yes, please explain: _____

Are you currently taking any medications? _____

Are you pregnant? _____

Is there any health related conditions, concerns, or questions that you want to disclose or ask prior to your service today?

Accident

Are your symptoms related to an accident? Yes ___ No ___ Auto Accident? Yes ___ No ___

Accident Date: _____ State in which accident occurred: _____

Employment –Related Injury (Worker’s Compensation)

Are your symptoms employment related? Yes ___ No ___ BWC Claim # _____ Injury Date: _____

Employer at time of injury: _____

Employer Address: _____
City State Zip

Emergency Contact

Emergency Contact: _____ Emergency Phone: _____

Emergency Address: _____
City State Zip

Relationship to Patient: _____

How did you select our services:

Doctor’s Referral _____ Friend’s Recommendation _____ Ad in City Paper _____

Val Pak Ad _____ Web Search _____ E-mail or Facebook _____ Other _____

What is your preferred contact method for appointment reminders?

Phone call _____ Text Message _____ E-mail _____ Other _____

Release Authorization for Treatment

I authorize wellness and/or aesthetic treatment provided by Serenity. I have answered the health related questions on this form honestly and completely. Though licensed in his or her specific service being provided at Serenity, I understand that my Serenity Therapist is not a medical physician or doctor and cannot diagnose or prescribe any medications, treatments, or services. I understand that Serenity and my therapist are not liable for any unforeseen medical issues that I may experience or complications that may arise that could be related to an undiagnosed, pre-existing medical condition prior to or after my treatment. I will disclose any concerns; health related or otherwise as well as discuss any pre-existing conditions to my therapist prior to receiving a treatment. I understand that I am responsible for my service charges at the time of service.

Patient Signature: _____ Date: _____
(Parent/Guardian if patient is a minor)