OASIS HEALTH HUB

Office Policy Agreement

Check-In & Late Arrivals

Please check in **15 minutes before your scheduled appointment time**. This allows us to complete any necessary paperwork and helps ensure that your visit begins on time.

We understand that delays occasionally happen. However, if you arrive late enough that your appointment must be rescheduled, a **$50 late fee** will apply.

Cancellations & No-Shows

We kindly request at least **24 hours' notice** if you need to cancel or reschedule your appointment.

Appointments canceled with less than 24 hours' notice and missed appointments (**no-shows**) will be charged the **full appointment fee**.

We understand that emergencies and unforeseen circumstances can occur. These situations will be reviewed on a case-by-case basis. When an exception is approved, your appointment may be rescheduled without an additional charge.

Same-Day & Urgent Appointments

We reserve a limited number of **same-day appointments for urgent medical concerns**. These appointments are subject to availability and fill quickly. Please call our office as soon as our phone lines open at **8:00 AM** if you need an urgent same-day appointment.

After-Hours Concerns & Emergencies

If you are experiencing a **serious or life-threatening medical emergency, call 911 or go directly to the nearest emergency room.**

Please do not use the patient portal or email for emergencies, as these methods of communication are not monitored continuously.

Insurance

Oasis Health Hub is a **fee-for-service practice and does not accept or bill health insurance**.

You are welcome to use your health insurance for outside laboratory testing, imaging, medications, or prescriptions when applicable. However, Oasis Health Hub is not responsible for insurance coverage decisions, denials, invoices, deductibles, or other billing issues related to services provided by outside facilities, laboratories, pharmacies, or your insurance carrier.

Self-Pay & Payment

Payment is due **in full at the time of service or at the time of online booking**, when applicable. We offer access to affordable comprehensive laboratory testing through our office.

We accept **credit cards, debit cards, and HSA cards**. We do not accept cash or checks. Credit card payments are subject to a **4% processing fee**.

Collections

Accounts that remain unpaid for **30 days** will begin our in-house collection process. If your balance reaches **65 days past due**, your account may be transferred to our collection agency.

If you are unable to pay your balance in full, please contact our office to discuss and establish a payment arrangement contract.

Membership Options

Oasis Health Hub memberships offer discounts on eligible visits, medications, and products. Please visit our website for current membership options and enrollment. **Membership is not mandatory.**

If you choose not to enroll in a membership but wish to use the patient portal for non-urgent questions or medical advice, a **$250 annual administrative fee** applies. This fee provides the convenience of ongoing portal access to our clinical team. Portal messaging is not appropriate for emergencies.

Medical Records

Medical records will be processed after we receive a **signed authorization/consent** from you. Please allow up to **5 business days** for processing.

Oasis Health Hub can provide records generated or ordered by our providers. Records received from previous or outside providers will not be re-released by our office; please request those records directly from the original provider or facility.

Patient Acknowledgment

I acknowledge that I have read, understand, and agree to Oasis Health Hub's Office Policy Agreement, including the appointment, cancellation, payment, collections, membership, communication, and medical records policies described above.

Patient Signature: _____

Printed Name: _____

Date: _____

Please retain a copy of this agreement for your records. Office policies may be updated periodically; the most current version will apply.

Oasis Health Hub, Inc.

Patient Registration Form

(Please Print in Black or Blue Ink)

Demographic Information

Name (Last, First)	MI	❑ Dr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Wheelchair Disabled ❑ Yes ❑ No	Ethnicity/ Race	Social Security Number	Birth Date: / /	Sex:	DL or ID #	
Street Address	Home Phone Number	Cell Phone Number				
City	State	Zip Code	Email Address			
Occupation	Employer	Employer Phone Number				
Pharmacy Name	Pharmacy Address	Pharmacy Phone Number				
Emergency Contact Name	Relationship to Patient	Phone Number				
Referred by:	Primary Care Physician:					

Primary Insurance Information

Patient's relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other
Insurance Type	❑ PPO/POS	❑ HMO	❑ Cash	❑ Other:

Subscriber's Name	Subscriber's Birth Date / /	Subscriber's Address (if different)	Subscriber's Phone Number
Subscriber's Employer	Subscriber's Employer Address	Subscriber's Employer Phone Number	
Insurance Name	Insurance ID Number	Group Number	Co Pay $
Start of Coverage	End of coverage	Subscriber Social Security Number	

Secondary Insurance Information

Patient's relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other:
Insurance Type	❑ PPO/POS	❑ HMO	❑ Cash	❑ Other:

Subscriber's Name	Subscriber's Birth Date / /	Subscriber's Address (if different)	Subscriber's Phone Number
Subscriber's Employer	Subscriber's Employer Address	Subscriber's Employer Phone Number	
Insurance Name	Insurance ID Number	Group Number	Co Pay $
Start of Coverage	End of coverage	Subscriber Social Security Number	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balances. I also authorize Oasis Health Hub, Inc. or insurance company to release any information required to process my claims. I am aware that I will be responsible for the payment of all bills in the event that my coverage is not active or if not in-network.

Patient or Representative Signature:_____ Date: _____

NOTICE OF PRIVACY PRACTICES

Effective September 4, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, AND HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to protected health information (PHI) maintained by Oasis Health Hub. PHI includes health information that identifies you or could reasonably be used to identify you, whether maintained electronically, on paper, verbally, or in photographs or other images.

YOUR RIGHTS

Get a copy of your medical record. You may inspect or request an electronic or paper copy of your medical record and other health information we maintain about you. We will provide access as required by law and may charge a reasonable, cost-based fee where permitted.

Ask us to correct your record. You may ask us to correct health information you believe is incorrect or incomplete. We may deny the request in certain circumstances, but we will explain the reason in writing when required.

Request confidential communications. You may ask us to contact you in a specific way or at a specific location. We will accommodate reasonable requests.

Ask us to limit what we use or share. You may request restrictions on certain uses or disclosures. We are not required to agree to every request. If you pay in full out-of-pocket for a service and ask us not to disclose information about that service to your health plan for payment or health care operations, we will honor the request unless disclosure is required by law.

Get a list of certain disclosures. You may request an accounting of certain disclosures of your health information, subject to legal exceptions and applicable time limits.

Get a copy of this Notice. You may request a paper or electronic copy at any time, even if you previously agreed to receive it electronically.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian or personal representative, that person may exercise your rights as permitted by law.

File a complaint without retaliation. You may complain to Oasis Health Hub or to the U.S. Department of Health and Human Services Office for Civil Rights if you believe your privacy rights have been violated. We will not retaliate against you for filing a complaint.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment. We may use and share your health information with physicians, clinicians, pharmacies, laboratories, imaging centers, specialists, and other professionals involved in your care.

Health care operations. We may use and share information to operate our practice, coordinate care, improve quality, train staff, conduct compliance activities, and contact you when necessary.

Payment and billing. We may use and disclose information to obtain payment or determine benefits when applicable, including disclosures to health plans, laboratories, or other entities. Oasis Health Hub is a fee-for-service practice, but payment-related disclosures may still occur when you choose to use insurance for outside services.

Public health and safety. When permitted or required by law, we may disclose information for disease prevention and reporting, product recalls, adverse-event reporting, reporting suspected abuse, neglect, or domestic violence, or preventing or reducing a serious threat to health or safety.

Research. We may use or disclose health information for research when all requirements of applicable law have been satisfied.

Required by law and health oversight. We may disclose information when federal, state, or local law requires it and for lawful health oversight activities such as audits, inspections, investigations, or licensure activities.

Organ and tissue donation; medical examiners and funeral directors. We may disclose information as permitted by law for organ procurement, identification of a deceased person, determining cause of death, or duties of a funeral director.

Workers' compensation, law enforcement, and government requests. We may disclose information when authorized by applicable law for workers' compensation claims, certain law-enforcement purposes, military or national-security activities, correctional institutions, and other government functions.

Lawsuits and legal proceedings. We may disclose information in response to a valid court or administrative order, subpoena, discovery request, or other lawful process when applicable legal requirements are met.

NOTICE OF PRIVACY PRACTICES - CONTINUED

CLINICAL PHOTOGRAPHS AND IMAGES

Clinical documentation. During your care, your provider may determine that photographs or other images of wounds, scars, skin lesions, swelling, hair loss, treatment sites, or other areas of medical concern are clinically useful to document findings, assist with diagnosis or treatment, and evaluate interval change. When created for these purposes, these images become part of your medical record and are protected as PHI. They will be used and disclosed only as permitted by applicable privacy law and Oasis Health Hub policies.

Education, advertising, social media, website, or other promotional use is different. Oasis Health Hub will not use identifiable clinical photographs or other PHI for marketing or promotional purposes unless you have signed a separate authorization that satisfies applicable law. Refusing such an authorization will not affect your treatment.

OTHER USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

For uses and disclosures not otherwise permitted or required by law, we will obtain your written authorization. This generally includes most uses or disclosures of PHI for marketing and a sale of PHI. You may revoke an authorization in writing at any time, except to the extent we have already acted in reliance on it or as otherwise provided by law.

SUBSTANCE USE DISORDER RECORDS

To the extent Oasis Health Hub creates, receives, or maintains substance use disorder patient records protected by 42 CFR Part 2, additional federal confidentiality protections may apply. Such records generally may not be used or disclosed in civil, criminal, administrative, or legislative investigations or proceedings against you without your written consent or a qualifying court order and subpoena, as required by law.

OUR RESPONSIBILITIES

• We are required by law to maintain the privacy and security of your protected health information.

• We will notify you as required by law if a breach occurs that may have compromised the privacy or security of your information.

• We must follow the duties and privacy practices described in the Notice currently in effect and make a copy available to you.

• We will not use or share your information other than as described in this Notice unless you authorize us in writing or another law permits or requires the use or disclosure.

• We may change the terms of this Notice. Changes may apply to all information we maintain about you. The current Notice will be available in our office and, when applicable, on our website.

QUESTIONS OR COMPLAINTS

Oasis Health Hub Privacy Officer
Phone: 520-552-4000 | Email: md@oasishealthhub.com
You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You will not be retaliated against for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT

My signature below acknowledges that I received or was offered a copy of Oasis Health Hub's Notice of Privacy Practices. My signature does not authorize uses or disclosures beyond those permitted by law and described in the Notice.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

REQUEST FOR SPECIAL RESTRICTION ON THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Oasis Health Hub, Inc. (OHH)

I understand that Oasis Health Hub, Inc. (OHH) may use or disclose my protected health information (PHI) for purposes of treatment, payment, and health care operations as permitted by law. OHH may also disclose relevant information to a person involved in my care or payment for my care, such as a family member, friend, caregiver, or other person I identify, when permitted by law.

I have the right to request that OHH restrict certain uses or disclosures of my PHI. I understand that **OHH is generally not required to agree to my requested restriction**. However, if OHH agrees to a restriction, OHH will comply with the agreed restriction except as permitted or required by law, including when information may be needed for emergency treatment. Certain requests involving disclosure to a health plan for payment or health care operations may be required to be honored when the applicable legal requirements are met, including when the item or service has been paid for in full out-of-pocket.

I understand that this request applies **only to records and information maintained or controlled by OHH**. OHH does not control the use or release of patient information maintained by other physicians, health care providers, laboratories, pharmacies, hospitals, imaging centers, or other organizations. I understand that I must contact those organizations directly to request restrictions on their use or disclosure of my information.

PATIENT REQUEST

I request that OHH restrict the following PHI:

_____

_____

_____

I request that the information listed above NOT be used or disclosed for the following purpose(s):

☐Treatment ☐Payment ☐Health care operations ☐Person involved in my care/payment ☐Other:

I request that the information NOT be disclosed to the following person(s), organization(s), or category of persons:

_____

_____

Reason for request (optional):

_____

PATIENT ACKNOWLEDGMENT

I understand that submitting this form does not mean my requested restriction has been approved. OHH will review my request and notify me whether it is accepted, partially accepted, or denied. I understand that an agreed restriction may be terminated or modified as permitted by law and that OHH will inform me when applicable.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

FOR OASIS HEALTH HUB USE ONLY

☐ Approved as requested ☐ Approved with modification ☐ Denied

Details / limitations:

_____

_____

Reviewed by: _____ Date: _____

LABORATORY SELECTION & FINANCIAL RESPONSIBILITY WAIVER

Please review and select your preferred laboratory before testing.

PLEASE SELECT ONE LABORATORY:

- ☐ **Quest Diagnostics**
- ☐ **LabCorp**
- ☐ **Access Labs — Self-pay testing performed in our office**

Insurance & Laboratory Responsibility

If you are uncertain which laboratory is contracted with your insurance plan, **please contact your insurance company prior to your appointment to confirm.**

Your health insurance policy is a contract between you and your insurance company. It is your responsibility to understand the terms of your plan, including laboratory benefits, preferred or contracted laboratories, deductibles, copayments, coinsurance, and prior-authorization requirements.

Oasis Health Hub cannot guarantee insurance coverage for laboratory testing. **Our office will not be held responsible for laboratory testing that is denied, considered out-of-network, applied to your deductible, or otherwise not covered by your insurance**, including specimens sent to a laboratory that is not contracted with your plan.

By selecting a laboratory and signing below, I acknowledge that I have had the opportunity to verify my laboratory benefits and accept financial responsibility for any laboratory charges not covered by my insurance plan.

PATIENT ACKNOWLEDGMENT

I have read and understand this Laboratory Selection & Financial Responsibility Waiver. I understand that it is my responsibility to verify laboratory coverage with my insurance company and that I am financially responsible for charges not covered by my insurance plan.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Please notify Oasis Health Hub if your insurance coverage or preferred laboratory changes.

MEDICAL PHOTOGRAPHY CONSENT & AUTHORIZATION

Clinical Documentation and Optional External Use

CLINICAL PHOTOGRAPHY FOR YOUR MEDICAL RECORD

I understand that my Oasis Health Hub provider may recommend photographs or other images of a wound, scar, skin lesion, area of swelling, hair or scalp condition, treatment site, or another area of medical concern when clinically useful. The purpose may include documenting my condition, assisting with diagnosis or treatment planning, monitoring healing or response to treatment, and comparing interval change over time.

Clinical photographs will be maintained as part of my medical record and treated as protected health information. Access, use, and disclosure will be limited in accordance with applicable privacy law and Oasis Health Hub privacy and security policies.

Please select one:

☐ I CONSENT to clinical photographs when my treating provider determines they are medically appropriate.

☐ I DO NOT CONSENT to routine clinical photographs. I understand there may be circumstances in which my provider will discuss

IMPORTANT: EDUCATIONAL, WEBSITE, SOCIAL MEDIA & MARKETING USE

Clinical consent above does **not** authorize Oasis Health Hub to use identifiable photographs, videos, or other protected health information for its website, social media, advertising, promotional materials, public presentations, or other marketing. Such use is optional and is not a condition of receiving treatment.

Optional authorization - complete only if you wish to allow external use:

☐ I AUTHORIZE Oasis Health Hub to use the photographs/images described below for the selected purposes.

☐ I DO NOT AUTHORIZE any educational, website, social media, advertising, or promotional use of my identifiable photographs/im

If authorizing external use, select permitted purposes: ☐ Medical education/presentations ☐ Oasis website ☐ Oasis social media ☐ Printed promotional materials ☐ Other: _____

Description of photographs/images authorized: _____
_____

Identification preference: ☐ Images may include my face/identifying features ☐ Use only images intended not to reveal my identity

Who may use/disclose the information: Oasis Health Hub and its workforce or contracted service providers acting on its behalf for the purposes selected above.
Who may receive it: Members of the public or audiences reached through the selected media, including internet and social-media users when those options are selected.

Expiration: Unless I write a different date here, this optional authorization expires five (5) years after the date I sign it: _____.

Right to revoke: I may revoke this optional authorization in writing at any time by contacting Oasis Health Hub. Revocation will not affect uses or disclosures already made in reliance on this authorization and may not allow Oasis Health Hub to retrieve materials already lawfully distributed or published.

Redisclosure: I understand that information disclosed to the public or to a recipient that is not subject to HIPAA may no longer be protected by HIPAA and may be redisclosed. I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing the optional external-use authorization.

PATIENT ACKNOWLEDGMENT

I have had the opportunity to ask questions about clinical photography and any optional external use. I understand the choices I have made above.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Provider/Witness (optional): _____

COMPREHENSIVE MEDICAL & WELLNESS HISTORY

Please complete this questionnaire as thoroughly as possible. Click a box to place a check mark, or print and mark by hand.

Name: _____ Date of Birth: _____

Preferred Name: _____ Pronouns (optional): _____

Phone: _____ Email: _____

Occupation: _____ Primary Care Provider: _____

How did you hear about Oasis Health Hub?

☐ Friend/Family ☐ Current Patient ☐ Provider ☐ Google/Search ☐ Social Media ☐ Event ☐ Other

Who referred you? _____

1. Reason for Your Visit

What is your primary reason for coming to Oasis Health Hub?

_____

_____

What are your top 3 health concerns or goals?

1. _____

2. _____

3. _____

☐ Energy/fatigue ☐ Hormone optimization ☐ Sexual health/libido ☐ Weight loss ☐ Muscle/strength ☐ Body composition ☐ Sleep
☐ Mood ☐ Memory/focus ☐ Metabolic health ☐ Cardiovascular health ☐ Gut health ☐ Longevity ☐ Hair/skin
☐ Pain/inflammation ☐ Performance/recovery

If treatment is successful, what would you most like to feel or be able to do differently?

_____

_____

2. Current Health & Symptoms

Overall health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Height: _____ **Current Weight:** _____ **Goal Weight (if applicable):** _____

Significant weight change in the past year? ☐ No ☐ Yes Explain: _____

☐ Fatigue/low energy ☐ Difficulty sleeping ☐ Snoring/sleep apnea ☐ Brain fog ☐ Memory concerns ☐ Difficulty concentrating
☐ Anxiety ☐ Depressed mood ☐ Irritability ☐ Headaches/migraines ☐ Dizziness ☐ Hot flashes/night sweats
☐ Temperature intolerance ☐ Decreased libido ☐ Sexual dysfunction ☐ Genital dryness/discomfort ☐ Erectile difficulties
☐ Menstrual changes ☐ Hair loss/thinning ☐ Skin changes ☐ Joint/muscle pain ☐ Chronic pain ☐ Muscle weakness/loss
☐ Difficulty losing weight ☐ Weight gain ☐ Cravings ☐ Constipation ☐ Diarrhea ☐ Bloating/gas ☐ Reflux ☐ Abdominal pain
☐ Palpitations ☐ Shortness of breath ☐ Swelling ☐ Urinary symptoms

Other symptoms: _____

3. Allergies

Medication allergies? ☐ No ☐ Yes

Medication / Substance	Reaction

Other allergies/sensitivities (food, latex, adhesives, environmental, etc.):
_____

4. Current Medications & Supplements

List all prescriptions, over-the-counter medications, hormones, peptides, supplements, vitamins, and injections.

Medication / Supplement	Dose	Frequency	Reason

Preferred Pharmacy: _____

5. Past Medical History

☐ High blood pressure ☐ High cholesterol ☐ Heart disease ☐ Heart attack ☐ Stroke/TIA ☐ Blood clot/DVT/PE ☐ Clotting disorder
☐ Diabetes/prediabetes ☐ Insulin resistance ☐ Obesity ☐ Thyroid disease ☐ Autoimmune disease ☐ Osteopenia/osteoporosis
☐ Kidney disease ☐ Liver/fatty liver disease ☐ Gallbladder disease ☐ Pancreatitis ☐ GERD ☐ IBS/IBD ☐ Cancer
☐ Anemia/iron deficiency ☐ Asthma/COPD ☐ Sleep apnea ☐ Migraine ☐ Seizure disorder ☐ Depression ☐ Anxiety ☐ ADHD
☐ Eating disorder ☐ Chronic pain ☐ Arthritis ☐ Infertility ☐ PCOS ☐ Endometriosis ☐ Fibroids ☐ Prostate disorder
☐ Erectile dysfunction

Please provide details for any conditions checked above:

_____

_____

_____

6. Past Surgical, Procedural & Hospitalization History

Surgery / Procedure / Hospitalization	Approx. Date	Reason

Significant scars from surgery, trauma, burns, or injuries? ☐ No ☐ Yes Location/cause: _____

7. Family History

☐ Heart disease/heart attack ☐ Stroke ☐ High blood pressure ☐ High cholesterol ☐ Diabetes ☐ Obesity
☐ Blood clots/clotting disorder ☐ Breast cancer ☐ Ovarian cancer ☐ Uterine/endometrial cancer ☐ Prostate cancer
☐ Colon cancer ☐ Pancreatic cancer ☐ Other cancer ☐ Thyroid disease ☐ Autoimmune disease ☐ Osteoporosis
☐ Alzheimer's/dementia ☐ Parkinson's disease ☐ Depression/anxiety ☐ Suicide ☐ Substance use disorder

Identify relative and approximate age at diagnosis when known:

_____

_____

_____

8. Social & Lifestyle History

Relationship status (optional): _____

Occupation: _____ **Typical work hours/week:** _____

Tobacco/nicotine: ☐ Never ☐ Former ☐ Current Type/amount: _____

Alcohol: ☐ None ☐ Occasional ☐ Weekly ☐ Daily Approx. drinks/week: _____

Cannabis: ☐ No ☐ Yes Frequency/type: _____

Current or previous recreational/non-prescribed drug use: ☐ No ☐ Yes Specify: _____

Exercise days/week: _____

☐ Walking ☐ Strength training ☐ Cardio ☐ Yoga/Pilates ☐ Sports ☐ Other

Average sleep: _____ hrs/night

Sleep quality: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Stress level: ☐ Low ☐ Moderate ☐ High ☐ Severe

☐ No specific diet ☐ Mediterranean ☐ Low carbohydrate ☐ Ketogenic ☐ Vegetarian ☐ Vegan ☐ Gluten-free
☐ Intermittent fasting ☐ High protein

Other dietary pattern: _____

9. Hormone & Reproductive History

Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to answer

Currently using hormone therapy? ☐ No ☐ Yes

Used hormone therapy in the past? ☐ No ☐ Yes
☐ Estrogen ☐ Progesterone ☐ Testosterone ☐ DHEA ☐ Thyroid hormone ☐ Pellets ☐ Injections ☐ Patches ☐ Creams/gels ☐ Oral therapy

Previous/current dose, duration, response, and any side effects:

_____

_____

_____

Anatomy - complete what applies:

Uterus: ☐ Yes ☐ No ☐ N/A

Ovaries: ☐ Both ☐ One ☐ None ☐ N/A

Prostate: ☐ Yes ☐ No ☐ N/A

If you menstruate or previously menstruated: Last menstrual period: _____
☐ Regular cycles ☐ Irregular cycles ☐ Perimenopausal ☐ Postmenopausal

Age at menopause: _____ Pregnancies: _____ Births: _____

Abnormal uterine/vaginal bleeding? ☐ No ☐ Yes

Abnormal Pap/HPV? ☐ No ☐ Yes

If you have a prostate:

Elevated PSA? ☐ No ☐ Yes

BPH/enlarged prostate? ☐ No ☐ Yes

Urinary symptoms? ☐ No ☐ Yes

10. Previous Peptide Therapy

Have you ever used peptide therapy? ☐ No ☐ Yes

Peptide	Duration / Dose	Reason	Results / Side Effects

Interested in learning about peptide therapy? ☐ No ☐ Yes ☐ Unsure

11. Weight-Loss & Metabolic Treatments

☐ Semaglutide ☐ Tirzepatide ☐ Retatrutide ☐ Other GLP-1 medication ☐ Metformin ☐ Prescription weight-loss medication
☐ Medical weight-loss program ☐ Bariatric surgery ☐ Continuous glucose monitor (CGM)

Treatment, duration, results, and side effects:

_____

_____

_____

12. Longevity, Regenerative & Integrative Treatments

☐ IV vitamin/nutrient therapy ☐ NAD+ therapy ☐ Peptide therapy ☐ PRP ☐ Exosome therapy ☐ Stem-cell/regenerative therapy
☐ Hyperbaric oxygen ☐ Red-light therapy ☐ Sauna/heat therapy ☐ Cold plunge/cryotherapy ☐ Neural therapy ☐ Acupuncture
☐ Functional medicine ☐ Nutritional therapy ☐ CGM ☐ Advanced cardiovascular testing ☐ Genetic testing
☐ Biological-age/longevity testing

Which treatments were most helpful and what outcomes did you notice?

_____

_____

Which treatments were not helpful or caused adverse effects?

_____

_____

13. Preventive Health & Screening

Approximate date of most recent testing (when applicable):

Routine physical	_____	Routine labs	_____
Blood pressure	_____	Lipid/cholesterol testing	_____
Colon cancer screening	_____	Bone density (DEXA)	_____
Mammogram/breast imaging	_____	Pap/HPV screening	_____
PSA/prostate screening	_____	Cardiac testing/CAC	_____

Genetic testing for hereditary cancer or cardiovascular risk? ☐ No ☐ Yes If yes: _____

14. Your Goals at Oasis Health Hub

☐ Improve energy ☐ Improve sleep ☐ Optimize hormones ☐ Improve sexual health/libido ☐ Lose body fat
☐ Build/preserve muscle ☐ Improve metabolic health ☐ Improve cardiovascular health ☐ Improve cognition/focus ☐ Improve mood
☐ Reduce inflammation/pain ☐ Improve gut health ☐ Improve performance/recovery ☐ Improve hair/skin ☐ Healthy aging/longevity
☐ Disease prevention/risk reduction ☐ Improve quality of life

What would you consider a successful outcome from working with Oasis Health Hub?

_____

_____

_____

_____

Anything else about your health, lifestyle, medical history, or goals you would like your provider to know?

_____

_____

_____

_____

PATIENT ATTESTATION

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that this information will be used by my healthcare provider to assist in evaluating my health and developing recommendations for my care.

Patient Name (Printed): _____

Patient Signature: _____ **Date:** _____