# **PATIENT REGISTRATION**

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| PLEASE PRINT AND COMPLETE ALL ENTRIES | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)** | | | | | | | | | | | | **ADDRESS** | | | | | | | | | | | | | | | |
| **CITY, STATE** | | | | | | | | | | **ZIP** | | | | | | **HOME PHONE** | | | | | | | | **CELL PHONE** | | | |
| **PATIENT DATE OF BIRTH** | | | **PATIENT SSN** | | | | | | | | **SEX**  **❑ Male ❑ Female** | | | | | | | | **MARITAL STATUS**  **❑ Single ❑ Married ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |  |
| **PATIENT EMPLOYER NAME** | | | | | **PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)** | | | | | | | | | | | | | | | | | | | | **EMPLOYER PHONE** | | |
| INSURED/RESPONSIBLE PARTY INFORMATION | | | | | | | | | | | | | RELATION TO PATIENT: ❑spouse ❑parent ❑guardian | | | | | | | | | | | | | | |
| **NAME (FIRST -- LAST -- MIDDLE INITIAL)** | | | | | | | | **ADDRESS (if different from patient)** | | | | | | | | | | | | | | | | | | | |
| **HOME PHONE** | | | **WORK PHONE** | | | | | **SSN** | | | | | | | | | **BIRTH DATE** | | | | **EMPLOYER** | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PRIMARY INSURANCE NAME** | | | | | | **ADDRESS (STREET - CITY - STATE - ZIP)** | | | | | | | | | | | | | | | **PHONE** | | | | | | |
| **GROUP NUMBER** | | **ID NUMBER** | | | | | **EMPLOYER** | | | | | | | | | | | | | **EMPLOYER PHONE** | | | | | | | |
| **SECONDARY INSURANCE NAME** | | | | | | **ADDRESS (STREET - CITY - STATE - ZIP)** | | | | | | | | | | | | | | | **PHONE** | | | | | | |
| **GROUP NUMBER** | | **ID NUMBER** | | | | | **EMPLOYER** | | | | | | | | | | | | | **EMPLOYER PHONE** | | | | | | | |
| **PRIMARY DOCTOR/FAMILY DOCTOR** | | | | | | | | | | | | | | | **REFFERING DOCTOR** | | | | | | | | | | | | |
| **IN CASE OF EMERGENCY CONTACT** | | | | | | | | | | | | | | | **RELATIONSHIP** | | | | | | | **PHONE NUMBER** | | | | | |
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| **ASSIGNMENT AND RELEASE :** I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE (Patient or, if minor Signature of parent or guardian)** | | | | | | | | | | | | | | **DATE** | | | | | | | | | | | | | |
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| **Authorization to release health information to:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name(s)** | | | | | | | | | | | | **ADDRESS** | | | | | | | | | | | | | | | |
| **CITY, STATE** | | | | | | | | | | **ZIP** | | | | | | **HOME PHONE** | | | | | | | | **DAYTIME PHONE** | | | |
| **DATES OF SERVICE**  **FROM: TO:** | | | | | | | | | | **AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)**  **❑ NEVER DATE:** | | | | | | | | | | | | | | | | | |
| Release the following information: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **❑ All Records** | | | | **❑ Chart Notes** | | | | | **❑ Radiology Reports** | | | | | | | | | **❑ Operative Reports** | | | | | | | | **❑ History & Physicals** | |
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| **RELEASE OF INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I understand that: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ● | once “this facility” discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ● | I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524). | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ● | my records are protected and cannot be disclosed without written permission | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ● | this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE** | | | | | | | | | | | | | | **DATE** | | | | | | | | | **EMAIL** | | | | |
| **IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT** | | | | | | | | | | | | | | **SIGNATURE OF WITNESS (Optional):** | | | | | | | | | | | | | |

# **PATIENT MEDICAL HISTORY**

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| **PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)** | | | | | | | | | | | | |
| **\*\*\* Preferred Pharmacy:** | | | | | | | | | | | | |
| **Allergies** |  | | | |  | | |  | | | |  |
| **❑** NONE/No Known Allergies | **❑** Adhesive Tape | | | | **❑** Anesthesia | | | **❑** Aspirin | | | | **❑** Codeine |
| **❑** Dairy Products | **❑** Iodine/Shellfish/Contrast Dye | | | | **❑** Latex | | | **❑** Morphine | | | | **❑** Penicillin |
| **❑** Sulfa Drugs | **❑** Wheat | | | |  | | |  | | | |  |
| **OTHER:** |  | | | |  | | |  | | | |  |
| **FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.** | | | | | | | | | | | | |
|  | | **MOTHER** | | | | **FATHER** | | | | | **SIBLING (Brother/Sister)** | |
| Anesthesia Problems | |  | | | |  | | | | |  | |
| Arthritis | |  | | | |  | | | | |  | |
| Cancer | |  | | | |  | | | | |  | |
| Diabetes | |  | | | |  | | | | |  | |
| Heart Problems | |  | | | |  | | | | |  | |
| Hypertension | |  | | | |  | | | | |  | |
| Stroke | |  | | | |  | | | | |  | |
| Thyroid Disorder | |  | | | |  | | | | |  | |
| **SOCIAL HISTORY** | | | | | | | | | | | | |
| **Marital status:** 🞎 Single 🞎 Married 🞎 Divorced 🞎 Widowed 🞎 Separated | | | | | | | | | | | | |
| **Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Retired 🞎 Disabled (reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | | | | | | | | | | | | |
| 🞎**Yes** 🞎**No -** Do you drink alcohol? 🞎 Daily 🞎Weekly 🞎Infrequently 🞎 Recovering Alcoholic | | | | | | | | | | | | |
| 🞎**Yes** 🞎**No -** Do you use tobacco? 🞎 Smoke ( \_\_\_ packs per day) 🞎 Chew | | | | | | | | | | | | |
| **Surgical History:** Please list any hospitalizations, surgeries, fractures or major illnesses you have had. | | | | | | | | | | | | |
| **TYPE OF SURGERY** | | | | **YEAR or DATE** | | | **DOCTOR** | | | | | **LOCATION** |
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| **Medical History:** Have you ever had any of the following? | | | | | | | | | | | | |
| **❑** NONE of the problems listed | | **❑** chest pain | | | | **❑** hyperlipidemia | | | | **❑** organ injury | | |
| **❑** allergies | | **❑** CHF congestive heart failure | | | | **❑** hypertension | | | | **❑** osteoporosis | | |
| **❑** anemia | | **❑** chronic fatigue syndrome | | | | **❑** hypogonadism male | | | | **❑** pulmonary embolism/blood clot in legs | | |
| **❑** arthritis conditions | | **❑** depression | | | | **❑** hypothyroidism | | | | **❑** seizure disorders | | |
| **❑** asthma | | **❑** diabetes | | | | **❑** infection problems | | | | **❑** shortness of breath | | |
| **❑** arterial fibrillation  **❑** bleeding problems  **❑** BPH  **❑** CAD coronary artery disease  **❑** cancer  **❑** cardiac arrest  **❑** celiac disease | | **❑** drug/alcohol abuse  **❑** erectile dysfunction  **❑** fibromyalgia  **❑** Gerd  **❑** heart disease  **❑** high cholesterol  **❑** hyperinsulinemia | | | | **❑** insomnia  **❑** irritable bowel syndrome  **❑** kidney problems  **❑** menopause  **❑** migraines/headaches  **❑** neuropathy  **❑** onychomycosis | | | | **❑** sinus conditions  **❑** stroke  **❑** syndrome X  **❑** tremors  **❑** wheat allergy | | |
| **Medications:** List any medications you are currently taking (please include over the counter medications):  **PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE** | | | | | | | | | | | | |
| MEDICATION | | | DOSAGE | | | | | | PERSCRIBING DOCTOR | | | |
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