# **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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