PATIENT REGISTRATION FORM

Today's Date:_____

Patient Information:

Last Name:_____ First Name:_____ Middle Initial:_____

Sex: ____Male ____Female Date of Birth:_____ SS#:_____ Home Phone:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Work Phone:_____ Mobile Phone:_____Patient Referred By:_____

Race :(check one) ___American Indian/Alaska Native ___Asian/Oriental ___Black/African American ___Native Hawaiian/Other Pacific Islander ___White ___Other ___Declined

Ethnicity: (check one) ___Central American ___Cuban ___Dominican ___Hispanic/Latino/Spanish ___Mexican ___Not Hispanic or Latino ___Puerto Rican ___South American ___Spaniard ___Other ___Declined

Marital Status: _____Single _____Married _____Other (widow,divorced,separated) Patient PCP:_____

Spouse's Name:_____ Spouse's Employer:_____ Spouse's Employer Phone:_____

Email address:_____

Guardian Information (If Applicable):

Last Name:_____ First Name:_____ MI:_____ Phone:_____

Street Address:_____ City:_____ State:_____ Zip Code_____

SS#:_____ DOB:_____ Employer Name:_____

Employer Address:_____ Employer Phone:_____

Emergency Contact Information:

Last Name:_____ First Name:_____ Phone:_____ Relationship:_____

Employer Information:

Employer Name:_____ Employer Phone:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Guarantor Information:

Last Name:_____ First Name:_____ MI:_____

Street Address:_____ City:_____

State: _____ Zip Code:_____ Phone:_____

DOB:_____ Employer Name:_____

Employer Address:_____ Employer Phone:_____

Insurance Information:

Insurance Plan Name:_____ nsurance Phone Number:_____ Policy ID Number:_____

Street Address for Claims:_____ City:_____ State:_____ Zip Code:_____

Patient's Relationship to Policy Holder:_____ Policy Group Number:_____ Effective Date:_____

Policy Holder Last Name:_____ Policy Holder First Name:_____ MI:____ Policy Holder Sex: ___Male ___Female

Injury and Workman's Compensation Information:

Is Injury Related to: ____Work ____Auto Accident ____Other Date of Injury:_____ Work Comp Claim #:_____

Case Manager/Adjuster Name:_____ Case Manager/Adjuster Phone Number:_____

ADULT MEDICAL HISTORY FORM

NAME_____ **BIRTHDATE**_____-_____-_____ **OCCUPATION**_____

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
2.				
3.				
4.				

MEDICATIONS

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			

ALLERGIES/SENSITIVITES TO MEDICATIONS/REACTION

_____

_____

PAST MEDICAL HISTORY

Have you ever been told you had one of the following? Please check Yes if you have now, or have had in the past.

	Yes	No		Yes	No
Allergies	☐	☐	Headaches/Migraine	☐	☐
Anemia	☐	☐	Hearing Loss	☐	☐
Anxiety	☐	☐	Heart Rhythm Disorder	☐	☐
Arthritis	☐	☐	Heart Disease	☐	☐
Asthma	☐	☐	Hypertension	☐	☐
Autoimmune Disease	☐	☐	Hyperlipidemia	☐	☐
Back/Neck Pain	☐	☐	Kidney Disease/Stones	☐	☐
Blood Disorder	☐	☐	Liver	☐	☐
Bowel Disease	☐	☐	Lung Disease	☐	☐
CAD	☐	☐	Mental Illness	☐	☐
CHF	☐	☐	Movement Disorder	☐	☐
COPD	☐	☐	Nerve Disease	☐	☐
Cancer	☐	☐	Osteopenia/Osteoporo	☐	☐
Dementia	☐	☐	Overweight/Obesity	☐	☐
Developmental	☐	☐	Pneumonia	☐	☐
Depression	☐	☐	Prostate Disorder	☐	☐
DM 1	☐	☐	Spine Disease	☐	☐
DM 2	☐	☐	Stroke/TIA	☐	☐
Diabetic Complications	☐	☐	Thyroid Disease	☐	☐
Endocrine Disease	☐	☐	Tuberculosis /Pos PPD	☐	☐
Eye Problems	☐	☐	Urinary Problems	☐	☐
Fibromyalgia/Pain	☐	☐	Viral Disease	☐	☐
Gastritis/Ulcer	☐	☐	Other		
GERD/Acid Reflux	☐	☐			

FAMILY HEALTH HISTORY

	RELATION	AGE OF ONSET	SIGNIFICANT HEALTH PROBLEMS
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Education: [ ] less than 8th grade [ ] High School [ ] 2 year college
[ ] 4 year college [ ] Post graduate [ ] Other _____

Marital Status: [ ] Married [ ] Single [ ] Divorced
[ ] Separated [ ] Widowed [ ] Domestic Partner

Exercise Level: [ ] None [ ] Occasional [ ] Moderate [ ] High level [ ] Other: _____

Tobacco: Do you currently use tobacco? [ ] Yes [ ] No
Did you use tobacco in the past? [ ] Yes [ ] No

How long: _____

[ ] Cigarettes- __/day [ ] Chew- __/day [ ] Cigars- ___/day

Alcohol: Do you drink alcohol? [ ] Yes [ ] No
If so, how often? [ ] Occasionally [ ] < 3 times/week
How many drinks per week? _____

Caffeine [ ] None [ ] Occasional [ ] Moderate [ ] Heavy # cups/cans per day? _____

Drugs Do you currently use recreational or street drugs? [ ] Yes [ ] No

Are you sexually active? [ ] Yes [ ] No
Are you interested in being screened for STD's? [ ] Yes [ ] No

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date: _____

Last Mammogram Date: _____

Date of last menstrual period or menopause: _____

Number of pregnancies: _____