**PATIENT REGISTRATION FORM**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt#: \_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SEX: □ Female □Male E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity**: □ Hispanic □ Non-Hispanic **Preferred Language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race**: □ American Indian and Alaska Native □ Bi-Racial □ Middle Eastern □ Hawaiian/Pacific Islander

 □ White/Caucasian □ Black or African American □ Other □ Unknown

Employed: Y / N PT / FT Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: S M D W Sep SO Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the Patient is NOTthe Subscriber (person who carries insurance) please provide additional information requested below:

**Primary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employed: Y / N PT / FT Subscriber Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Physician**: (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiologist**: (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Name**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO TREAT**: I, the undersigned, hereby consent to and authorize all diagnostic and therapeutic treatment performed at our locations considered necessary or advisable in the judgment of the physician.

**ASSIGNEMENT OF BENEFITS**: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private or group insurance, or other health plans to our offices.

**RELEASE OF MEDICAL INFORMATION**: I hereby give permission for our offices to release my medical information pertaining to the care I receive from this office to my insurance company if so, requested in order to achieve payment.

**FINANCIAL RESPONSIBLILTY**: I accept ultimate financial responsibility for all charges incurred with our offices whether paid by insurance or not.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Release of Medical Information:**

I certify that I was made available a copy of the “Notice of Protected Health Information Practices”. I hereby authorize this office to release any of my medical or incidental information, including billing information, that may be necessary for medical care or to process medical insurance claims

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friends(s).

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_

**I do not wish my information to be disclosed to any person. Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization to Mail, Call or E-Mail:**

I certify that I understand the privacy risks of the mail, phone calls and emails. I hereby authorize a representative or my physician to mail, call or email me with communications regarding my healthcare, such as appointment reminders and/or medical information regarding patient care. I understand that I have the right to revoke consent for any and all the above initialed items at any time in writing.

 **Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying current insurance information, and payment of any services not covered or approved by my insurance carrier.

Signature of Patient or Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_

***MEDICAL HISTORY***

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AGE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEIGHT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WEIGHT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE DOCTOR**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ANY MEDICATIONS YOU ARE TAKING, INCLUDING NON -PRESCRIPTION DRUGS, VITAMINS, AND HERBALS. (Use back if necessary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking, or have you taken Fen/Phen, Redux, or any other weight reduction medication? YES NO

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Do you have now or have had within the past year:  |  |  |
| fatigue fever night sweats weight loss weight gain eye discharge vision loss ear discharge hearing loss ringing in the ears nasal drainage difficulty swallowing  chronic cough shortness of breath wheezing  | YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO  | chest pain rapid heartbeat leg pain when walking abdominal pain blood in stool chg. in bowel habits constipation diarrhea vomiting painful urination excessive urination blood in urinecold intolerance heat intolerance excessive thirst | YES NO excessive hunger YES NO difficulty walking YES NO depression YES NO seizures YES NO rash YES NO itchy skin YES NO change in moles YES NO joint / bone pain YES NO muscle weakness YES NO easy bleeding YES NO easy bruising YES NO swollen lymph nodes YES NO environmental allergiesYES NO food allergies   | YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO  |

Women Only:

Age Period Began \_\_\_\_\_\_ Number of Pregnancies \_\_\_\_\_\_\_ Live Births\_\_\_\_\_ Miscarriages/Abortions \_\_\_\_\_\_

Date of Last Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_ Result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you do regular breast self-examinations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a breast lump or discharge? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start date of last menstrual cycle (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY:**

Have you ever had the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| AIDS or HIV+ | YES NO | Tuberculosis | YES NO | Radiation | YES NO |
| Anemia | YES NO | Glaucoma | YES NO | Rheumatic Fever | YES NO |
| Arthritis | YES NO | Heart Disease | YES NO | Stomach Ulcer | YES NO |
| Asthma | YES NO | Mitral Valve Prolapse | YES NO | Stroke | YES NO |
| Bleeding Tendency | YES NO | High Blood Pressure | YES NO | Thyroid Disease | YES NO |
| Chemotherapy | YES NO | Kidney Disease | YES NO | Diabetes | YES NO |
| Cancer  | YES NO | Hepatitis | YES NO |  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

LIST PREVIOUS SURGERIES (Use back if necessary):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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LIST MAJOR ILLNESSES/HOSPITALIZATIONS (Use back if necessary):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY** **HISTORY:**

Has any blood relative ever had any of the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diabetes | YES NO | High Blood Pressure | YES NO | Kidney Disease | YES NO |
| Stroke | YES NO | Heart Disease | YES NO | Depression | YES NO |
| Melanoma | YES NO | Breast Cancer | YES NO | Other Cancers | YES NO |
| Relatives: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relatives: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Type & Relatives: |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SOCIAL HISTORY:**

Smoking YES NO Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Packs Per Day: \_\_\_\_\_\_\_\_\_\_

If Former Smoker, Date Quit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are a CURRENT Smoker have you ever tried to quit? YES NO Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Use: None Occasional Moderate Excessive

How many days have you had 5 or more drinks in the last year?\_\_\_\_\_\_\_

 Drug Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

*Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

