

Patient Registration

Legal Name: _____ DOB: _____

Nick Name: _____

Home Address: _____ SS#: _____ - _____ - _____

Mailing Address and Home Address are the same?

Mailing Address: _____ Birth Gender (circle): M / F

Identify As (circle or complete): He/She/They/Them _____

Phone (please check preferred) Emergency Contact

Home: _____ Name: _____

Work: _____ Phone: _____

Cell: _____ Relationship: _____

Email: _____

May we leave a detailed message on voice mail at? Home / Work / Cell

Insurance Carrier: _____

Subscriber: _____ DOB: _____

Identification Number: _____ / _____

Group Number: _____

***Please show your insurance card to the front desk at every visit.**

Are you Medicaid Eligible? Yes / No

Are you uninsured? Yes / No

Race/Ethnicity:

Are you American Indian? Yes / No

Are you Alaskan Native? Yes / No

Other: _____

Language(s) Spoken: _____

NAME: _____ DOB: _____

Previous Primary Care Provider

Name: _____
Address: _____ Phone: _____
_____ Fax #: _____

***Please notify your insurance, if needed, for change in primary care provider.**

Are you seeing us by referral for a consult only? Yes / No
If no, are you required to choose a PCP with your insurance? Yes / No
If yes, have you contacted the insurance company to do so?
Effective Date _____

Have you had your medical records transferred to us? Yes / No
If no, please ask the receptionist for a medical release form so that we may request them on your behalf. You will need the previous facilities name, address, phone and fax number.

Do you have Advanced Directives?
Living Will: Yes / No
Durable Power of Attorney: Yes / No
Does our office have a copy of these? Yes / No

Household Members:

Name: _____
Relationship: _____ Age: _____
Name: _____
Relationship: _____ Age: _____

Preferred Pharmacy:

Name: _____
Address: _____ Phone: _____

NAME: _____ DOB: _____

PERSONAL MEDICAL INFORMATION

Reason for Today's Visit: _____

Past Medical History: Check box or write in current or previous health conditions

| | | | |
|------------------------------|--------------------------|----------------------|--------------------------|
| Alcohol/Drug Use | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> |
| Bleeding/Clotting Tendencies | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> |
| Chronic Pain | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> |
| Congenital Defects | <input type="checkbox"/> | Mononucleosis | <input type="checkbox"/> |
| Convulsive Disorder | <input type="checkbox"/> | Neurologic Disease | <input type="checkbox"/> |
| COPD/Asthma | <input type="checkbox"/> | Renal/Kidney Disease | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | Sleeping Disorder | <input type="checkbox"/> |
| Gastrointestinal Disease | <input type="checkbox"/> | Smoking History | <input type="checkbox"/> |
| Genital/Urologic Disease | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | | |

Allergies:

- 1) Medication: _____ Reaction: _____
- 2) Medication: _____ Reaction: _____
- 3) Medication: _____ Reaction: _____
- 4) Environmental: _____
- 5) Food: _____

Date of last immunization (please bring vaccination record to visit):

- Influenza: Date _____
- Pneumovax (PPSV23): Date _____
- Prevnar (PCV13): Date _____
- Tetanus/Tdap: Date _____
- Shingrix (Shingles): Date _____

Have you ever had Chicken Pox? Yes / No

What year or how old: _____

NAME: _____ DOB: _____

Family History: please check box and circle relationship to you

PGF: Paternal Grandfather PGM: Paternal Grandmother
 MGF: Maternal Grandfather MGM: Maternal Grandmother
 M: Mother F: Father B: Brother S: Sister

| | | | | | | | | | |
|---------------------------|--------------------------|-----|-----|-----|-----|---|---|---|---|
| Arthritis (Type _____) | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| Asthma/COPD (Circle) | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| Cancer (type): | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| Coronary Artery Disease | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| Depression/Anxiety | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| Diabetes | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| GI Disorders (Type _____) | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| High Cholesterol | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| Hypertension | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| Migraines | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| Obesity | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| Stroke | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |
| Other: | <input type="checkbox"/> | PGF | PGM | MGF | MGM | M | F | B | S |

Social History:

Married/Single/Divorced/Widow (please circle)

Occupation: _____ Education: _____

Health Prevention/Health Promotion:

| | | | | | | | |
|-----------------|----------|-------------------------|--|-------|----------|-------|--|
| Smoke Detector: | Yes / No | | | | | | |
| C02 Detectors: | Yes / No | | | | | | |
| Exercise: | Yes / No | Frequency? | | | | | |
| Alcohol: | Yes / No | How much? How often? | | Quit: | Yes / No | Date: | |
| Tobacco: | Yes / No | How much? | | Quit: | Yes / No | Date: | |
| Drug Use: | Yes / No | | | Quit: | Yes / No | Date: | |
| Caffeine Usage: | Yes / No | Cups per day? | | Quit: | Yes / No | Date: | |
| Seatbelt Use: | Yes / No | | | | | | |
| Helmet Use: | Yes / No | | | | | | |
| Sunscreen: | Yes / No | | | | | | |

NAME: _____ DOB: _____

Do you follow a particular diet?

What type of diet? _____

Females Only:

When was your last menstrual period? _____

Number of Pregnancies? _____

Number of Births? _____

Have you traveled to other countries within the last year? Yes / No

Where: _____ Date: _____

Where: _____ Date: _____

Medications: *Please include all current medications, including over the counter and supplements

(Use back of last page for additional medications)

Name: _____ Dose: _____ Frequency: _____

Hospital/Surgical History:

Explain: _____

Date: _____ Facility: _____

Explain: _____

Date: _____ Facility: _____

Explain: _____

Date: _____ Facility: _____

Other Healthcare Providers (Complete if Appropriate)

Dentist: _____ Location: _____ Last Visit: _____

Eye Doctor: _____ Location: _____ Last Visit: _____

Gynecologist: _____ Location: _____ Last Visit: _____

Urologist: _____ Location: _____ Last Visit: _____

Orthopedist: _____ Location: _____ Last Visit: _____

Cardiologist: _____ Location: _____ Last Visit: _____

Dermatologist: _____ Location: _____ Last Visit: _____

Gastroenterologist: _____ Location: _____ Last Visit: _____

Endocrinologist: _____ Location: _____ Last Visit: _____

NAME: _____ **DOB:** _____

Other Pertinent Medical Information You Would Like To Share With Us?

Patient Signature: _____

Date: _____

Parental/Guardian Signature: _____

Date: _____

Signature of Reviewing Provider: _____

Date: _____