

- Patient Information -

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ Cell Phone (____) _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

- Primary Insurance -

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

- Additional Insurance -

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

- Assignment and Release -

I certify that I, and/or my dependent(s), have insurance coverage with _____ and
Name of Insurance Company(ies)

assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative

 Date

 Please print name of Patient, Parent, Guardian or Personal Representative

 Relationship to Patient

- Registration Form -

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

- Symptoms -

Check (✓) conditions you currently have or have had in the past year.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes
- Vision - Halos

MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other _____

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children _____

- Conditions -

Check (✓) conditions you currently have or have had in the past year.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |

- Medications -

List medications you are currently taking.

Pharmacy Name _____ Phone _____

- Allergies -

- Health History -

- Family History -

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

- Hospitalizations -

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

- Pregnancies -

Year of Birth	Sex of Birth	Complications if any

- Health Habits -

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

- Occupational -

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date