REGISTRATION INFORMATION

PATIENT INFORMATION:

How did you hear about us? ______________________________Today's Date: ________________

Lastname: _______________First ______________Middle ____________Maiden ___________

BIRTHDATE ______________SOCIAL SECURITY# _____________________ Gender: _____

EMAIL: ____

Name you go by: _____________Home Phone: ___ _________ Work Phone:_______________

Cell: ___ __________Any other numbers like beeper, etc: ______________________________

STREET ADDRESS ____

CITY ________________________STATE __________ZIP CODE __________________

RESPONSIBLE PARTY (If Patient is a minor) ____

Special Category: **Race:**

Employer: ______________________________________RETIRED? _______________________

Employer Contact Person _________________________EMPLOYER PHONE# ________________

EMPLOYER ADDRESS ____

MISCELLANEOUS INFORMATION:

Previous Doctor _____________________Reason for Change: ___________________________

His/Her Phone/Address ____

SPOUSE INFORMATION:

NAME ____________________________________EMPLOYER ____________________

WORK PHONE ________________SOCIAL SECURITY# _____________BIRTH DATE _________

INSURANCE AND POLICY HOLDER INFORMATION:

Insurance Company: ________________Policy Holder Name: ______________His/Her SSN:_________

His/Her BirthDate:__________His/Her Relationship with you__________His/Her Employer____________

What is your **deductible**:_________How much deductible you have met:________**Coinsurance** %:__________

Do you have a **pre-existing illness** clause?:____

EMERGENCY CONTACT ___________________________PHONE#______________________

Closest friend or relative not living with you for emergency contact: _______________________________

RELEASE AND ASSIGNMENT:

I authorize release of any information necessary to process my insurance claim and assign and request payment directly to my physicians. I understand that any portion of services that are not covered by insurance are the responsibility of the patient. Payment is expected at the time of service unless prior financial arrangements have been made. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

DO YOU HAVE A LIVING WILL? _____________

WHO MAY WE RELEASE YOUR MEDICAL INFORMATION OTHER THAN YOURSELF?

____

PATIENT SIGNATURE __________________________________DATE ____

HEALTH HISTORY (CONFIDENTIAL)

Name_________________________________ ____Today's Date_________________Birthdate_____________

Reason for visit?______________________________________ Date of last physical_____________________

Symptoms (Please Checkmark)

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

Endocrine
- ☐ High blood sugar
- ☐ Low blood sugar

ENT
- ☐ Bleeding gums
- ☐ Ear discharge
- ☐ Earache
- ☐ Hard of hearing
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Post nasal drainage
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-flashes
- ☐ Vision-halos

Eye
- ☐ Blurring of vision
- ☐ Crossed eye
- ☐ Double vision

General
- ☐ Chills
- ☐ Fatigue/Malaise
- ☐ Fever
- ☐ Night sweats

Gastrointestinal
- ☐ Black stool
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas or Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor appetite
- ☐ Rectal bleed
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

- ☐ Weight gain
- ☐ Weight loss

Genitourinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful / burning urination

Hematology
- ☐ Anemia
- ☐ Bleed easily

Men
- ☐ Breast lump
- ☐ Erection problem
- ☐ Lump in testicle
- ☐ Penis discharge
- ☐ Sore on penis

Musculoskeletal
- ☐ Arm or leg pain
- ☐ Back pain
- ☐ Joint pain

Neurological
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Headache
- ☐ Increase sleep
- ☐ Loss of sleep
- ☐ Numbness

Other
- ☐ Other (Write)

Psychiatric
- ☐ Depression
- ☐ Nervousness

Respiratory
- ☐ Cough
- ☐ Shortness of breath

Skin
- ☐ Change in moles
- ☐ Easy bruising
- ☐ Hives or Itching
- ☐ Rash or Scars
- ☐ Sore that won't heal

Women
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Irregular periods
- ☐ Lump in breast
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Very heavy periods

Conditions you have or have had in the past (Please Circle)

- ☐ AIDS / HIV Positive
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis / Removal
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump / Cancer
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cataracts / Surgery
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Gallstones / Surgery
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea / Syphilis
- ☐ Gout
- ☐ Heart Disease / Attack
- ☐ Hepatitis/ Liver disease
- ☐ Hernia
- ☐ Herpes / Chlamydia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hysterectomy
- ☐ Kidney Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage / Abortion
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Murmur
- ☐ Pacemaker
- ☐ Peptic ulcers
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus/Nasal Allergy
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis / Removal
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Vaginal Infections

Medications:

Allergies:_________________________________ ________________________Pharmacy:_________________________

Last period date__________Pap smear date____________Mammogram date_____Pregnant?______Children?____

FAMILY HISTORY

Relation	Age	State of Health	Age at Death	Cause of Death	Mark	Disease	Relationship
Father						Asthma, Hay Fever	
Mother						Cancer	
Brothers						Diabetes	
						Heart Disease	
						Stroke	
						High Blood Pressure	
Sisters							

Indicate if Blood Relatives have any of these

Hospitalizations/Operations/Serious Illnesses/Injuries/Current Conditions

Year	Details	Hospital

Pregnancy History

Year	Sex	Complications

Social Habits

Yes/No		How Much
	Caffeine	
	Smoking	
	Alcohol	
	Cocaine	
	Marijuana	
	Heroin-Other	

Occupational Exposures

Yes/No	
	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Have you ever had a blood transfusion: Give Dates

Occupation:

I certify that the above information is accurate to the best my knowledge.

Signature: ______________________ Date: ____________