PATIENT REGISTRATION

NAME _____ SS# _____

STREET ADDRESS _____ DATE OF BIRTH _____ MARITAL STATUS: S M W SEP D

CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME _____ OFFICE _____

REFERRED BY _____

SPOUSE'S NAME _____

SPOUSE'S EMPLOYER / ADDRESS _____

EMERGENCY CONTACT _____ TEL. # _____ RELATIONSHIP _____

PATIENT EMPLOYER INFORMATION

EMPLOYER NAME _____ TEL # _____

EMPLOYER STREET ADDRESS _____ CITY / STATE _____ ZIP _____

PATIENT'S OCCUPATION _____

INSURED PERSON (IF NOT PATIENT)

NAME _____ TEL # _____

STREET ADDRESS _____ CITY / STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

INSURANCE

MEDICAID # (IF APPLICABLE) _____ MEDICARE # (IF APPLICABLE) _____

PRIMARY INSURANCE COMPANY NAME _____

ID # _____ GROUP # _____ TEL.# _____

SECONDARY INSURANCE COMPANY NAME _____

ID # _____ GROUP # _____ TEL.# _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

DATE _____ SIGNATURE _____

I HEREBY AUTHORIZE DR. _____ TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY HIM/HER, OR BY HIS/HER ORDER. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DR. _____ (OR TO THE PARTY WHO ACCEPTS ASSIGNMENT).

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING.

DATE _____ SIGNATURE _____
(PATIENT, PARENT, OR GUARDIAN)

NAME

GENERAL MEDICAL INFORMATION

DESCRIBE THE CURRENT MEDICAL PROBLEM/REASON FOR TODAY'S VISIT: _____

PRESENT MEDICATIONS: _____

ALLERGIES TO MEDICATION: _____

ALLERGIES (E.G., ITCHINESS OR HIVES) TO SPECIFIC BRANDS OF SOAP/LAUNDRY DETERGENT: _____

OTHER PHYSICIANS CURRENTLY TREATING YOU: _____

PREVIOUS OR OTHER MEDICAL PROBLEMS: _____

LIST ANY PREVIOUS SURGERIES OR HOSPITALIZATIONS (INCLUDE NUMBER OF MISCARRIAGES AND LIVE BIRTHS): _____

_____

FEMALES ONLY: ARE YOU PREGNANT, PLANNING A PREGNANCY OR NURSING A CHILD? ❑ YES ❑ NO

DO YOU SMOKE? ❑ NO ❑ YES ❑ CIGARETTES ❑ PIPE ❑ CIGARS NO. OF YEARS _____ HOW MUCH? _____

INTERESTED IN STOPPING? ❑ YES ❑ NO

DO YOU REGULARLY DRINK ALCOHOL? ❑ YES ❑ NO HOW MANY OUNCES/BEERS PER DAY? _____

DO YOU REGULARLY DRINK COFFEE? ❑ YES ❑ NO HOW MANY CUPS PER DAY? _____

ARE YOU UNDER A LOT OF PRESSURE AT WORK? ❑ YES ❑ NO PLEASE DESCRIBE: _____

_____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following (*check all that apply*):

❑ CHEST PAIN/PRESSURE/TIGHTENING _____	❑ ASTHMA _____	❑ KIDNEY DISEASE _____
❑ HYPERTENSION _____	❑ DIZZY SPELLS _____	❑ SHORTNESS OF BREATH _____
❑ HEART ATTACK _____	❑ CANCER _____	❑ TB/LUNG DISORDER _____
❑ STROKE _____	❑ DIABETES _____	❑ ULCERS _____
❑ HEADACHES _____	❑ ARTHRITIS _____	❑ SKIN DISORDERS _____
❑ GLAUCOMA _____	❑ DIFFICULTY HEARING _____	❑ HEPATITIS _____
❑ ALLERGIES OR ECZEMA _____	❑ GLAUCOMA _____	❑ CATARACTS _____
❑ DEPRESSION _____	❑ MEMORY LOSS _____	❑ DIGESTIVE PROBLEMS _____
❑ BLOOD IN STOOL _____	❑ HEMORRHOIDS _____	❑ FREQUENT URINARY INFECTIONS _____

❑ OTHER: _____

IMMUNIZATIONS

(YEAR LAST RECEIVED, IF KNOWN)

SMALLPOX _____

TETANUS _____

TYPHOID _____

POLIO _____

INFLUENZA _____

PNEUMONIA _____

RUBELLA _____

HEPATITIS _____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
HIGH BLOOD PRESSURE	❑	❑	❑	❑	❑	❑
EPILEPSY	❑	❑	❑	❑	❑	❑
CANCER	❑	❑	❑	❑	❑	❑
ECZEMA / PSORIASIS	❑	❑	❑	❑	❑	❑
HEART ATTACK / STROKE	❑	❑	❑	❑	❑	❑
DIABETES	❑	❑	❑	❑	❑	❑
ASTHMA	❑	❑	❑	❑	❑	❑
HAY FEVER	❑	❑	❑	❑	❑	❑