Patient Registration

Welcome to our office. We look forward to establishing a comfortable and secure relationship with you. You are important to us and we want you to feel special every time you call or walk into this office. Please take a few minutes to read and complete this form. This information is necessary to make sure you receive the best care during your visit and to minimize any misunderstanding which may occur due to incorrect or incomplete information.

PATIENT INFORMATION

First Name: _____ Last Name: _____ Today's Date: _____

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Best Phone: _____ Secondary Phone: _____

email: _____

DOB: _____ Age: _____ Social Security #: _____ / _____ / _____ Sex ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ W ☐ D

Primary Care Physician: _____ Referring Physician: _____

Employer: _____ Address: _____ Phone: _____

Reason For Today's Visit: _____

INSURANCE INFORMATION

Insurance And Responsible Party Information: ☐ SELF ☐ SPOUSE ☐ PARENT

If other than self please fill out the following information:

Insurance Carrier: _____ Primary Card Holder: _____ DOB: _____

Social Security #: _____ / _____ / _____ Relation: _____

ETHNIC BACKGROUND INFORMATION (Required by Healthcare Legislation)

RACE: ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Indian ☐ African American ☐ Other

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: _____

PHARMACY

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Printed Legal Name: _____ **Signature:** _____

NASHVILLE
SURGICAL ASSOCIATES

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Ray HARGREAVES, MD ✦ Jonathan COHEN, MD ✦ Sirinya PRASERTVIT, MD

Name: _____ Age: _____ Today's Date: _____

REASON FOR TODAY'S VISIT: _____

Referring Doctor: _____ Primary Care Doctor (if different): _____

MEDICAL HISTORY (Please Check)

☐ Alcohol / Substance Abuse (Past or Present)
☐ Arthritis
☐ Asthma
☐ Blood Clots
☐ Cancer _____
☐ Cardiac Stenting / Angioplasty
☐ COPD / Emphysema
☐ Depression or Anxiety
☐ Diabetes
☐ Gout
☐ Heart Attack (MI)
☐ Heart Disease
☐ Heart Murmur
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV +
☐ Kidney Disease
☐ Liver Disease or Hepatitis
☐ Nervous Disorder
☐ Reflux / Heartburn
☐ Rheumatic Fever
☐ Seizures
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis

OPERATIONS	DATE	SURGEON/HOSPITAL

Have you ever had MRSA? ☐ No ☐ Yes If Yes, when: _____

Do you have any Food Allergies? ☐ No ☐ Yes: _____

Are you Allergic to any medication? ☐ No ☐ Yes: _____

Do you take any Medication on a regular basis? *Please include vitamins, supplements, and OTC medicine.* LIST DOSAGE.

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Occupation: _____

Smoking: ☐ No ☐ Yes Amount: _____ *packs/day*

Alcohol: ☐ No ☐ Yes Amount: _____ */ week*

Family History of Cancer? ☐ No ☐ Yes

Type of Cancer: _____

Family relation *(example: Mother)* _____

FOR WOMEN:

Have you ever taken hormones? ☐ No ☐ Yes

Your age at menopause?: _____

How many times have you been pregnant?: _____

Number of deliveries?: _____

TO BE COMPLETED BY OFFICE MEDICAL ASSISTANT

Blood Pressure: _____ Weight: _____ Height: _____

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