

# 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: \_\_\_\_\_



Revised 4.21.2020

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ GI: \_\_\_\_\_ OB/GYN: \_\_\_\_\_

**FOR MD ONLY** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_ Are You A Jehovah's Witness?  No  Yes

**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

List any PAST MEDICAL PROBLEMS:	List any SURGERY OR MEDICAL PROCEDURE(s):
_____	_____
_____	_____
_____	_____

What MEDICINES do you take? *Please include vitamins, supplements, and OTC medicine.* LIST DOSAGE.

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

List MEDICATION AND FOOD ALLERGIES

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

Have you ever had MRSA?  No  Yes If "yes, when?: \_\_\_\_\_

Do you currently **SMOKE**?  No  Yes If "yes," how many packs per day?: \_\_\_\_\_

Have you ever been a smoker?  No  Yes If "yes," for how many years?: \_\_\_\_\_ When did you quit?: \_\_\_\_\_

If you use alcohol, how many alcoholic beverages do you consume per week?: \_\_\_\_\_

Have you ever had a problem with drinking too much alcohol?  No  Yes

When was your last Flu immunization?: \_\_\_\_\_ Pneumonia immunization?: \_\_\_\_\_

FAMILY HISTORY: please list the family relation according to the following conditions (*i.e. Crohn's Disease: paternal uncle*)

Cancer: \_\_\_\_\_ Stroke: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Heart Disease: \_\_\_\_\_

Gastrointestinal Disorder: \_\_\_\_\_ Crohn's Disease: \_\_\_\_\_ Ulcerative Colitis: \_\_\_\_\_

**TO BE COMPLETED BY OFFICE MEDICAL ASSISTANT**

Blood Pressure: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

*Please complete the opposite side*

**PLEASE CHECK ANY OF THE FOLLOWING IF YOU HAVE/HAD:**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Chills                            | <input type="checkbox"/> Asbestos Exposure       | <input type="checkbox"/> Blood in the Urine         | <input type="checkbox"/> Abnormal Bleeding       |
| <input type="checkbox"/> Fatigue                           | <input type="checkbox"/> Aspiration              | <input type="checkbox"/> Cancer of Urinary Organs   | <input type="checkbox"/> Abnormal Bruising       |
| <input type="checkbox"/> Fever                             | <input type="checkbox"/> Asthma or COPD          | <input type="checkbox"/> Erectile Dysfunction       | <input type="checkbox"/> Anemia                  |
| <input type="checkbox"/> Night Sweats                      | <input type="checkbox"/> Cigarette Smoking       | <input type="checkbox"/> Genital Lesion             | <input type="checkbox"/> Low Blood Count         |
| <input type="checkbox"/> Weight Loss                       | <input type="checkbox"/> Collapsed Lung          | <input type="checkbox"/> Female Cancer/Surgery      | <input type="checkbox"/> Blood Clotting Disorder |
| <hr/>  | <input type="checkbox"/> Lung Surgery            | <input type="checkbox"/> Kidney Failure             | <input type="checkbox"/> Disease of Blood Cells  |
| <input type="checkbox"/> Cataract                          | <input type="checkbox"/> Chronic Coughing        | <input type="checkbox"/> Kidney/Bladder Stones      | <input type="checkbox"/> Lymph Node Enlargement  |
| <input type="checkbox"/> Glaucoma                          | <input type="checkbox"/> Coughing up Blood       | <input type="checkbox"/> Polycystic Kidney Disease  | <hr/>  |
| <input type="checkbox"/> Macular Degeneration              | <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Prostate Enlargement       | <input type="checkbox"/> Alcohol Abuse           |
| <input type="checkbox"/> Vision Change                     | <input type="checkbox"/> Lung Cancer             | <input type="checkbox"/> Prostate Surgery           | <input type="checkbox"/> Drug Abuse              |
| <input type="checkbox"/> Diabetic Retinopathy              | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Urinary Incontinence       | <input type="checkbox"/> Eating Disorder         |
| <hr/>  | <input type="checkbox"/> Tuberculosis Exposure   | <input type="checkbox"/> Urinary Infection/Cystitis | <input type="checkbox"/> Anxiety                 |
| <input type="checkbox"/> Difficulty Swallowing             | <hr/>  | <input type="checkbox"/> Urinary Retention          | <input type="checkbox"/> Bipolar Disorder        |
| <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> Abdominal Pain          | <input type="checkbox"/> Urinary Tract Obstruction  | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> Nosebleeds                        | <input type="checkbox"/> Bloody or Dark Stool    | <hr/>   | <input type="checkbox"/> Schizophrenia           |
| <input type="checkbox"/> Obstructive Sleep Apnea           | <input type="checkbox"/> Chronic Nausea          | <input type="checkbox"/> Hernia                     | <input type="checkbox"/> Psychosis               |
| <input type="checkbox"/> Mass/Lesion of Mouth              | <input type="checkbox"/> Chronic Vomiting        | <input type="checkbox"/> Arthritis                  | <hr/>  |
| <input type="checkbox"/> Voice Change                      | <input type="checkbox"/> Cirrhosis/Hepatitis     | <input type="checkbox"/> Joint Complaints           | <input type="checkbox"/> Scleroderma             |
| <input type="checkbox"/> Head or Neck Cancer               | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Osteoporosis               | <input type="checkbox"/> Drug Allergy            |
| <hr/>  | <input type="checkbox"/> Incontinence of Stool   | <hr/>   | <input type="checkbox"/> Food Allergy            |
| <input type="checkbox"/> Chest Pain/Pressure               | <input type="checkbox"/> Pancreatitis            | <input type="checkbox"/> Headache                   | <input type="checkbox"/> HIV or AIDS             |
| <input type="checkbox"/> Exercise Intolerance              | <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Herniated Disc             | <input type="checkbox"/> Lupus                   |
| <input type="checkbox"/> Fainting                          | <input type="checkbox"/> Vomiting Blood          | <input type="checkbox"/> Sciatica                   | <input type="checkbox"/> Sarcoidosis             |
| <input type="checkbox"/> Heart Attack                      | <input type="checkbox"/> Yellowing Skin/Eyes     | <input type="checkbox"/> Memory Loss                |  |
| <input type="checkbox"/> Heart Rhythm Problem              | <input type="checkbox"/> Chronic Constipation    | <input type="checkbox"/> Parkinson's Disease        |  |
| <input type="checkbox"/> Pacemaker                         | <input type="checkbox"/> Chronic Diarrhea        | <input type="checkbox"/> Seizure                    |  |
| <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> Stroke or TIA              |  |
| <input type="checkbox"/> Leg Pain with Walking             | <input type="checkbox"/> Hemorrhoids             | <hr/>   |  |
| <input type="checkbox"/> Leg Swelling                      | <input type="checkbox"/> Irritable Bowel         | <input type="checkbox"/> Adrenal Gland Disorder     |  |
| <input type="checkbox"/> Heart Murmur                      | <input type="checkbox"/> Spastic Colon           | <input type="checkbox"/> Diabetes                   |  |
| <input type="checkbox"/> Palpitations                      | <input type="checkbox"/> Anal Surgery/Disease    | <input type="checkbox"/> Parathyroid Disease        |  |
| <input type="checkbox"/> Heart Procedure<br>(Stent/Bypass) | <hr/>  | <input type="checkbox"/> Pituitary Gland Disorder   |  |
| <input type="checkbox"/> Shortness of Breath               | <input type="checkbox"/> Change in Skin Color    | <input type="checkbox"/> Thyroid Disease            |  |
|  | <input type="checkbox"/> Keloid                  | <input type="checkbox"/> Thyroid Surgery            |  |
|  | <input type="checkbox"/> Mole Change             |   |  |
|  | <input type="checkbox"/> Skin Cancer             |   |  |

**Please list any additional information:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_