



Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS			
CITY, STATE		ZIP	HOME CELL		EMAIL ADDRESS
PATIENT DATE OF BIRTH	PATIENT SSN	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
PATIENT EMPLOYER NAME		PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)			EMPLOYER PHONE
INSURED/RESPONSIBLE PARTY INFORMATION		RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian			
NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER	
INSURANCE INFORMATION					
PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)			PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)			PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
PRIMARY DOCTOR/FAMILY DOCTOR			REFERRING DOCTOR		
IN CASE OF EMERGENCY CONTACT			RELATIONSHIP	PHONE NUMBER	

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE
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Authorization to release health information to:

Name(s)		ADDRESS			
CITY, STATE		ZIP	HOME PHONE	DAYTIME PHONE	
DATES OF SERVICE		AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)			
FROM:	TO:	<input type="checkbox"/> NEVER DATE:			
Release the following information:					
<input type="checkbox"/> All Records <input type="checkbox"/> Chart Notes <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Operative Reports <input type="checkbox"/> History & Physicals					

RELEASE OF INFORMATION

I understand that:

- "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Practice Manager

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	



PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST) and Date of Birth

*** What are your concerns?

Allergies

- NONE/No Known Allergies Adhesive Tape Anesthesia Aspirin Codeine
 Dairy Products Iodine/Shellfish/Contrast Dye Latex Morphine Penicillin
 Sulfa Drugs Wheat

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

- Marital status:** Single Married Divorced Widowed Separated
Occupation: _____ Retired Disabled (reason _____)
 Yes No - Do you drink alcohol? Daily Weekly Infrequently Recovering Alcoholic
 Yes No - Do you use tobacco? Smoke (_____ packs per day) Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> NONE of the problems listed | <input type="checkbox"/> chest pain | <input type="checkbox"/> hyperlipidemia | <input type="checkbox"/> organ injury |
| <input type="checkbox"/> allergies | <input type="checkbox"/> CHF congestive heart failure | <input type="checkbox"/> hypertension | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> chronic fatigue syndrome | <input type="checkbox"/> hypogonadism male | <input type="checkbox"/> pulmonary embolism/blood clot in legs |
| <input type="checkbox"/> arthritis conditions | <input type="checkbox"/> depression | <input type="checkbox"/> hypothyroidism | <input type="checkbox"/> seizure disorders |
| <input type="checkbox"/> asthma | <input type="checkbox"/> diabetes | <input type="checkbox"/> infection problems | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> arterial fibrillation | <input type="checkbox"/> drug/alcohol abuse | <input type="checkbox"/> insomnia | <input type="checkbox"/> sinus conditions |
| <input type="checkbox"/> bleeding problems | <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> irritable bowel syndrome | <input type="checkbox"/> stroke |
| <input type="checkbox"/> BPH | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> kidney problems | <input type="checkbox"/> syndrome X |
| <input type="checkbox"/> CAD coronary artery disease | <input type="checkbox"/> Gerd | <input type="checkbox"/> menopause | <input type="checkbox"/> tremors |
| <input type="checkbox"/> cancer | <input type="checkbox"/> heart disease | <input type="checkbox"/> migraines/headaches | <input type="checkbox"/> wheat allergy |
| <input type="checkbox"/> cardiac arrest | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> neuropathy | |
| <input type="checkbox"/> celiac disease | <input type="checkbox"/> hyperinsulinemia | <input type="checkbox"/> onychomycosis | |

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

Vitals:
Height _____ Weight _____ Temp _____ Pulse _____ RR _____ BP _____ / _____ Spo2 _____ LMP: _____ / _____ / _____