PATIENT REGISTRATION FORM

Revised 04/2012

PATIENT INFORMATION

Name: (First, MI, Last)	Sex	Home Phone:	
Address: (Street#)		Social Security #:	
City, State	Zip	DOB	Marital Status
Employer	Job Title	Work phone #:	Cell phone #:
Name and phone number of emergency contact			
Email Address:		May we correspond by email? ☐ Yes ☐ No	

REFERRING PHYSICIAN INFORMATION

Referred by:	Office Phone #:
Address	

FINANCIAL RESPONSIBILITY

Name of person financially responsible: (if patient is a minor)		Relationship to Patient:
Address: (Street#, City, State, Zip) ** If different than patient**		
Phone #	DOB	Social Security #

INSURANCE INFORMATION

Primary Insurance carrier	Group #	ID #	
Policy Holder's Name (First, MI, last)	PCP Co-pay amount	Specialist Co-pay amount	
Address: (Street#, City, State, Zip) ** If different than patient**			
Phone #	Relationship	DOB	Sex
Employer	Social Security#	Effective date of insurance	
Secondary Insurance carrier	Group #	ID #	
Policy Holder's Name		Relationship to patient	

Patient Signature ______________________ Date ______________

ADULT PATIENT HEALTH HISTORY

The information completed on this questionnaire will become a confidential part of your medical record.

Today's Date: ____/____/____

Name: ____ Date of birth: ____/____/____
Last First Middle

Reason for visit: ____

Current symptoms: ____

Primary Care Physician Information
Physician Name: ________________________
Address: ________________________
Phone: ____________ Fax: ____________

MEDICAL HISTORY

ILLNESSES:

Check major, significant illnesses which apply to you:

- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeding/Blood Disorder
- ☐ Breast cancer
- ☐ Cancer(s) ____________
- ☐ Cataracts
- ☐ Colitis
- ☐ Depression
- ☐ Constipation
- ☐ Emotional/Mental Illnesses
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Problems
- ☐ Hepatitis/Jaundice
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Polymyalgia Rheumatica (PMR)
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis/TB
- ☐ Rheumatoid Arthritis
- ☐ Other: ____________

SURGICAL:

List any operations/procedures you have had: ________________________

____

MEDICATIONS

List all medications you are currently taking which have been ordered by a doctor (including inhalers) and all over the counter drugs, vitamins or herbs. Please list prescribed medications first,

YOUR PHARMACY NAME AND LOCATION: ________________________ Phone____________

Name of Medicine/Dose/Frequency:

1. ________________________
2. ________________________
3. ________________________
4. ________________________
5. ________________________
6. ________________________
7. ________________________
8. ________________________
9. ________________________
10. ________________________

IMMUNIZATIONS:

Date of most recent:

_______________ Flu (once annually)
_______________ Pneumonia (Once every 5 years)
_______________ Tetanus
_______________ Shingles

ALLERGIES

☐ Medications: List/Describe:

____

☐ Food ☐ Animals ☐Latex ☐Tape ☐ Pollens ☐ Eggs ☐ Iodine ☐ Nuts
Other: ____

SOCIAL HISTORY

Occupation: ____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partner

What is your smoking status? ☐ Never ☐Past ☐Current

a. Year Quit: ____________
b. Number of years smoked: ____________
c. Average number of packs/day: ____ ☐ Chewing tobacco ☐Cigarettes

On average, how many alcoholic drinks (1 drink = 12 oz. beer, 10 oz. wine cooler, 5 oz. wine, 1.5 oz liquor) do you consume? ☐ Non-drinker ☐ 1-2 per week ☐ 1-2 per day ☐ 3 or more per day ☐ other________
a. Do you drink every day? ☐ Yes ☐ No
b. Have you ever thought you had a problem with drinking? ☐ Yes ☐ No

Any street drug use? ☐ Yes ☐ No If yes, substance? __________, how long? ____________________

FAMILY HISTORY

FAMILY ILLNESSES:

Check any illnesses which have occurred in a blood related brother (b), sister (s), mother (m), father (f) or grandparent (g):

	WHO
☐ Rheumatoid Arthritis	________
☐ Lupus	________
☐ Gout	________
☐ Colitis	________
☐ Psoriasis	________
☐ Cancer (type) ________	________