# Patient Registration Form

Date of Appointment: _____

## Patient Information

| Patient's First Name | Middle Name | Last Name (as it appears on insurance card or ID) |
|---|---|---|
| | | |

| Sex | Marital Status | Date of Birth (Age) | Social Security Number |
|---|---|---|---|
| | | | |

| Patient's Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Mobile Phone | Email Address |
|---|---|---|
| | | |

| Referred by | Primary Care Physician | Primary Care Physician Phone |
|---|---|---|
| | | |

| Pharmacy | Pharmacy Phone | Pharmacy Address |
|---|---|---|
| | | |

### Patient Employer/School Information

| Employer/School | Occupation | Employer/School Phone |
|---|---|---|
| | | |

| Employer/School Address | City | State | Zip |
|---|---|---|---|
| | | | |

### Emergency Contact Information

| Emergency Contact Name | Emergency Contact Phone | Relation to Patient |
|---|---|---|
| | | |

## Billing and Insurance

### Primary Health Insurance

| Insurance Company | Plan |
|---|---|
| | |

| Plan Number | Group Number | Insured's Employer/School |
|---|---|---|
| | | |

| Insured's Name (as it appears on insurance card or ID) | Relation to Patient | Insured's Phone Number |
|---|---|---|
| | | |

| Insured's Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Insured's Social Security Number | Insured's Birthdate | |
|---|---|---|
| | | |

### Secondary Health Insurance

| Insurance Company | Plan |
|---|---|
| | |

| Plan Number | Group Number | Insured's Employer/School | Insured's Social Security Number |
|---|---|---|---|
| | | | |

| Insured's Name (as it appears on insurance card or ID) | Relation to Patient | Insured's Phone Number |
|---|---|---|
| | | |

### Responsible Party

| Billing Name (if other than patient) | Phone | Relation to Patient |
|---|---|---|
| | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

_____ _____

Signature of Patient or Authorized Guardian | Date

Name _____ Gender _____ Age _____

Date of Appointment: _____

## Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

## Current Medications

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

## Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

## Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

## Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

## Women Only:

# of Pregnancies _____ # of Miscarraiges _____ # of Abortions _____ # of Living _____

Last Pap Smear _____ Last Mammogram _____ Birth Control Method _____

## Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

## Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

# drinks/week _____

How much caffeine do you drink per day?

# drinks/day _____

How often do you exercise?

# times/week _____

Name _____ Gender _____ Age _____ Date of Appointment: _____

## Review of Systems

### General
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth – Excessive
- ☐ Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst - Excessive
- ☐ Weight Gain
- ☐ Weight Loss

### Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Interest
- ☐ Feeling Hopeless
- ☐ Hearing Voices
- ☐ Marital Problems
- ☐ Panic Attacks
- ☐ Trouble Concentrating
- ☐ Suicide –Thoughts/Attempts

### Skin
- ☐ Acne
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Chills
- ☐ Dry / Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores That Won't Heal

### Gastrointestinal
- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal Disorder
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

### Genitourinary
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination

### Neurological
- ☐ Coordination Problems
- ☐ Convulsions
- ☐ Difficulty Walking
- ☐ Learning Disabilities
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tremors

### ENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Halos

### Respiratory
- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

### Cardiovascular
- ☐ Chest Pains
- ☐ Irregular Heart Beat
- ☐ Circulation Problems
- ☐ Heart Palpitations
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

### Musculoskeletal
- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Shoulder Pain

### Men Only
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penile Discharge
- ☐ Sore on Penis

### Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge

### Other Symptoms

_____

_____

_____

## Health Exams & Procedures

Please check and date the last time you had each exam or procedure performed.

| | Month & Year | | Month & Year |
|---|---|---|---|
| ☐ Cholesterol Test | _____ | ☐ MRI | _____ |
| ☐ Colonoscopy | _____ | ☐ Physical Exam | _____ |
| ☐ CT/CAT Scan | _____ | ☐ Cardiac Stress Test | _____ |
| ☐ EKG | _____ | ☐ Ultra Sound | _____ |
| ☐ Echocardiogram | _____ | | |

## Immunizations

Please check and date all immunizations you have had.

| | Month & Year | | Month & Year |
|---|---|---|---|
| ☐ Hepatitis A | _____ | ☐ MMR (Measles, Mumps, Rubella) | _____ |
| ☐ Hepatitis B (Series of 3) | _____ | ☐ Pneumonia | _____ |
| ☐ HPV Vaccine | _____ | ☐ Polio | _____ |
| ☐ Influenza (Flu Shot) | _____ | ☐ Tetanus | _____ |
| ☐ Meningitis | _____ | | |