◆Greg Rainwater M.D., Matthew Rainwater M.D., Chao Vang N.P.

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PATIENT REGISTRATION

PATIENT INFORMATION

Patient: ____
Last Name First Name Middle Name

Home Phone : __________ Daytime Phone : __________ Cell Phone : __________ Pager : __________

Street Address : ____

City : __________ State : __________ Zip: __________

Sex : ❑ M ❑ F Age : ______ Birthdate: __________ ❑ Single ❑ Married ❑ Widowed ❑ Seperated ❑ Divorced

Social Secutiry: __________ Driver's License: __________

Patient Employed By: __________ Business Phone: __________

Referring Physician: __________ Primary Physician: __________
Full Name Full Name

SPOUSE/RESPONSIBLE PARTY INFORMATION

Responsibile Party (if Patient is a minor): __________ Relationship to Patient: __________

Address : __________ City : __________ Zip: __________

Social Secutiry: __________ Driver's License: __________ Birthdate: __________

Employer : __________ Occupation: __________

Business Address : __________ Day/Business Phone #: __________

Spouse: __________ Driving Licence #: __________ Birth Date: __________

Employed By: __________ Occupation: __________

Business Address: __________ Day/Business Phone #: __________

IN CASE OF EMERGENCY (RELATIVE OR FRIEND)	RELATIONSHIP	TELEPHONE

CONSENT

I hereby give consent to release or obtain information to/from physicians and other medical personnel, as may be required in the rendering of treatment. I understand that I am financially responsible to the above named office for the services rendered. In the event of collection action, I shall be responsible for any legal fees incurred. This authorization expires one (1) year from the date of signature.

Patient / Responsible Party Signature Date / Date / Date

ASSIGNMENT

I hereby authorize payment directly to the attending physician of any medical/surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

Patient / Responsible Party Signature Date / Date / Date

INSURANCE INFORMATION

Name of the Primary Insurer: __________

Address : __________

Policy #: __________ Group #: __________ Subscriber: __________

Name of Secondary Insurer (if any) : __________

Address : __________

Policy #: __________ Group #: __________ Subscriber: __________

MEDICARE/MEDI-CAL INFORMATION

❑ **Medicare** ❑ **Medical Claim ID #:** __________

Medicare Secondary Payer Information :

Are you covered by a medical insurance plan where you work? ❑ Yes ❑ No

Are you covered by a medical insurance plan from your spouse's employer ? ❑ Yes ❑ No

Do you have any medical insurance., Other than Medicare? ❑ Yes ❑ No

Is that Medicare supplemental insurance? ❑ Yes ❑ No

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PATIENT HISTORY FORM

NAME ____________________________

DATE ____________________________

CHIEF COMPLAINT :

In your own words, why are you seeing the doctor today:

____

____

How long has this problem been present?

Have recent tests been performed for this problem (X-rays, urine cultures, blood tests)

____

What facility were these tests performed at? ____________________________

PAST MEDICAL AND SOCIAL HISTORY :

Do you currently smoke? _______ yes _______ no How many packs? _______________ How many years? _______________

Have you ever smoked? _______ yes _______ no How many packs? _______________ How many years? _______________

Have you ever quit smoking _______ yes _______ no For how long? _______________

Marital Status _______ single_______ married _______ widowed _______ divorced

Children _______ yes _______ no How many? _______

Do you drink alcohol? _______ Never_______ Rarely _______ Moderately _______ Heavy

Occupation?____________________________

ALLERGIES TO MEDICATIONS AND REACTIONS :

____

____

____

CURRENT PRESCRIPTION MEDICINES YOU TAKE ON A REGULAR BASIS:

________________________ ________________________

________________________ ________________________

________________________ ________________________

LIST AND DATE ANY PREVIOUS SURGERIES YOU HAVE HAD :

____

____

____

DOES ANYONE IN YOUR IMMEDIATE FAMILY HAVE? (PLEASE CIRCLE)

○ Diabetes ○ Bladder Cancer ○ Tuberculosis

○ High Blood Pressure ○ Prostate Cancer ○ Heart Disease

○ Kidney Stones ○ Colon/Rectal Cancer ○ Other: ____________________________

****PLEASE TURN FORM OVER AND COMPLETE BACK****

REVIEW OF SYSTEMS

AS PART OF YOUR CURRENT PROBLEM DO, YOU HAVE:

	YES	NO
CONSTITUTIONAL SYMPTOMS		
FEVER/CHILLS/SWEATS		
TIRED		
HEADACHES		

	YES	NO
CONSTITUTIONAL SYMPTOMS		
FEVER/CHILLS/SWEATS		
TIRED		
HEADACHES		

DO YOU HAVE NOW OR HAVE YOU EVER HAD:

	YES	NO
ALLERGIC/IMMUNOLOGIC		
HAYFEVER		
DRUG ALLERGIES		
OTHER		
ENDOCRINE		
THYROID PROBLEMS		
DIABETES		
HORMONE IMBALANCE		
TIRED/SLUGGISH		
HOT FLASHES		
OTHER		

	YES	NO
GASTROINTESTINAL		
ABDOMINAL PAIN		
NAUSEA/VOMITING/BLOOD		
INDIGESTION/HEARTBRUN		
CONSTIPATION		
DIARRHEA		
OTHER		
RESPIRATORY		
WHEEZING		
FREQUENT COUGH		
SHORTNESS OF BREATH		
OTHER		

HAVE YOU EVER BEEN TREATED FOR:

	YES	NO
INIEGUMENTARY		
SKIN RASH		
BOILS		
PERSISTENT ITCH		
OTHER		
MUSCULOSKELETAL		
JOINT PAIN		
NECK PAIN		
BACK PAIN		
OTHER		
EYES		
BLURRED VISION		
DOUBLE VISION		
EYE PAIN		
OTHER		
EAR/NOSE/THROAT		
EAR INFECTION		
SORE THROAT		
SINUS PROBLEMS		
NOSE BLEEDS		
OTHER		
GENITOURINARY		
URINARY RETENTION		
PAINFUL RETENTION		
URINARY FREQUENCY		
BLOOD IN URINE		
OTHER		

	YES	NO
HEMATOLOGIC/LYMPHATIC		
SWOLLEN GLANDS		
BLOOD CLOTTING PROBLEMS		
OTHER		
CARDIOVASCULAR		
CHEST PAIN		
HEART ATTACK		
VARICOSE VEIN		
HIGH BLOOD PRESSURE		
PATIGUE		
IRREGULAR HEARTBEAT		
SHORTNESS OF BREATH		
OTHER		
NEUROLOGIC		
TREMORS		
DIZZY SPELLS		
NUMBNESS/TINGLING		
SEIZURES		
STROKES		
PASSING OUT		
OTHER		
PSYCHOLOGICAL		
DEPRESSION		
ANXIETY		
MENTAL ILLNESS		
OTHER		

NO CHANGE PREVIOUS VISIT ON ____________________

REVIEWED BY : ______________________________ **DATE:** ____________________