**Form 1 YCMC Patient Information**

# NEW PATIENT REGISTRATION FORM

Please fill out this form completely. The following information will help us in providing you the best medical care and treatment possible. If you have any questions, please contact the office. Thank you and we look forward to seeing you!

# PATIENT INFORMATION

First Name

Last Name

**Marital status** (choose one)

|  |  |  |
| --- | --- | --- |
| Minor | Single | Married |
| Widowed | Separated | Divorced |

Date of Birth

SSN

**Sex** (choose one)

 Male  Female

Mailing Address

City

State

Zip Code

Cell Phone

Home Phone

Email Address

**Where do you prefer to receive calls?** (choose one)

 Home  Work  Either

# ADDITIONAL INFORMATION

Employer name

Employer address

Employer phone

If you are a student, name of school/college

**Race** (choose one)

 American Indian or Alaska Native  Asian  Black or African American

 Hispanic  Native Hawaiian or Pacific Islander

 White

 Other  Decline

Preferred Language

Emergency Contact Name

Who is your Primary Care Provider (PCP)?

Other physicians treating you

# RESPONSIBLE PARTY

Medicaid number (if applicable)

Medicare number )if applicable)

Primary Insurance Name

Policy ID

Group ID

Policy Holder's Name

Policy Holder's DOB

Policy Holder's SSN

**Patient Relationship to Policy Holder** (choose one)

 Self  Dependent  Spouse

 Other

# SECONDARY INSURANCE INFORMATION

Secondary Insurance Name

Policy ID

Group ID

Policy Holder's Name

Policy Holder's DOB

Policy Holder's SSN

Patient Relationship to Policy Holder

# MEDICAL HISTORY

Reason for Visit/Current Medical Problem

Please list all medications you are currently taking (including over the counter and vitamins/supplements)

Pharmacy/Name and Phone

Please list any allergies/intolerances to medications/itchiness or hives to specific brands of soap/laundry detergents

**Please check all that apply** (choose one)

|  |  |  |
| --- | --- | --- |
| Chest pain/pressure/tightening | Heart Disease | High Blood Pressure |
| Hypertension | Heart Attack | High Cholesterol |
| Arthritis | Diabetes | Headache |
| Dizziness | Diabetes | Seizure |
| Mental | Asthma | Depression |
| Stroke | Hypothyroidism | Kidney disease |
| Shortness of breath | TB/lung disorder | Ulcers |
| Skin disorder | Glaucoma | Allergies or eczema |
| Depression | Blood in stool | Difficulty hearing |
| Anemia | Memory loss | Hemorrhoids |
| Hepatitis | Cataracts | Digestive problems |
| Frequent urinary infection | Cancer | None |



Type of Cancer

*(If Applicable)*

Other

*(If Applicable)*

Hepatitis C Risk Factors

|  |  |  |
| --- | --- | --- |
| Blood transfusion before 1992 | IV Drug use-1 time | Contact with blood/bodily fluid |
| Tattoos | Shared razor/toothbrush | Body Piercing |



# SOCIAL HISTORY

Females only: Are you pregnant, planning a pregnancy or nursing a child

 yes  no

**Do you smoke?** (choose one)

 No  Yes  Occasionally

How many cigarettes per day?

*(If Applicable)*

How many years?

*(If applicable)*

**Any other forms of tobacco?** (choose one)

 No  Yes  Occasionally

List

*(If Applicable)*

How many years?

*(If applicable)*

**Do you drink alcohol?** (choose one)

 No  Yes  Occasionally

How many ounces/beers each day?

*(If Applicable)*

**Do you use any illicit drugs?** (choose one)

 No  Yes  Occasionally

List

*(If Applicable)*

**Do you regularly drink coffee?** (choose one)

 Yes  No

**Are you under a lot of pressure at work?** (choose one)

 Yes  No

If yes, please describe

*(If applicable)*

# FAMILY HISTORY

Does anyone in your family (living or deceased) have the following:

|  |  |  |
| --- | --- | --- |
| High Blood Pressure | High Cholesterol | Cancer |
| Stroke | Heart Disease | Diabetes |
| Depression | Mental Illness | Hypothyroidism |

# SURGICAL HISTORY

Please select/list all surgeries-related or unrelated to pain

Please check all that apply:

|  |  |  |
| --- | --- | --- |
| Appendix | Tonsils/Adenoids | Hysterectomy |
| Gallbladder | C-Sections | Heart |

Other

# INFORMATION AND ASSESSMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

Signature and date

I HEREBY AUTHORIZE REBECCA MCCLAIN FNP TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY HER, OR HER ORDER. I REQUEST THAT PAYMENT FROM MY

INSURANCE COMPANY BE MADE DIRECTLY TO REBECCA MCCLAIN (OR TO THE PARTY THAT ACCEPTS ASSIGNMENT).I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COMPANY IS CORRECT.I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR

MY INSURANCE COMPANY AT ANY TIME IN WRITING.

Signature and Date