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Patient Registration Forms

Today's Date: _____

Patient Name: _____

(First) (Middle) (Last)

Date Of Birth: _____ **Social Security Number:**_____

Current Address:_____

Home Phone Number: _____ **Cell Phone Number:**_____

Email: _____**Best form Of Contact:** _____

Emergency Contact: _____

(Name) (Phone Number) (Relationship)

Marital Status: _____ **(Single, Married, Divorce, or Other)**

Race: _____ **Ethnicity:** _____ **Hispanic or Latino:** □ **Yes** □ **No**

Occupation: _____ **Name of Employer:** _____

Insurance Information:

Primary Carrier: _____**Policy Number:**_____

Subscribers name and relationship: _____

Secondary Carrier: _____**Policy Number:**_____

Subscribers name and relationship: _____

By signing below, I confirm that the above information is accurate and correct.

Signature _____ **Date** _____

Recent Hospitalization: _____ **Last Colonoscopy:** _____

Last Mammogram: _____ **Last Eye Exam:** _____

Last Pap Test: _____ **Last Physical:** _____

#_____ Of Pregnancies
#_____ Of Children
Last Menstrual Period: _____

Prevention

Do you have pain?	Yes/ No	If yes, where? _____ Pain level (1-10): _____
Do you drink alcoholic beverages?	Yes/ No	If yes, how many drinks per week? _____
Do you drink coffee/ Tea?	Yes/ No	
Are you depressed?	Yes/ No	If yes, do you want to harm yourself or others? _____
Do you have a "living will"?	Yes/ No	
Do you use drugs?	Yes/ No	If yes, identify type: _____ # of years used: _____
Would you like to be tested for STD's?	Yes/ No	
Are you afraid of your partner?	Yes/ No	
Do you Smoke?	Yes/ No	If yes, amount per day: _____ # of years used: _____

List Present Complaints

_____

_____

_____

Additional Information

Name of Pharmacy: _____ **Pharmacy Phone#:** _____

Previous Primary Care Physician: _____ **Office phone#:** _____

By signing, I confirm that all the information provided is correct.

_____ _____ _____

Print Name Signature Date

Do you have any Allergies? Yes □ No □ If yes,

Please List _____, _____, _____, _____ Reaction Type _____

List of Current Medications

Medication Name	Dose	Direction
1_____	_____	_____
2_____	_____	_____
3_____	_____	_____
4_____	_____	_____
5_____	_____	_____

(Please circle) Past Medical History

1. High Blood Pressure
2. Diabetes
3. High Cholesterol
4. Heart Disease
5. Stroke
6. Peripheral Vascular Disease
7. Asthma
8. Pneumonia
9. COPD
10. Cancer_____
11. Rheumatic Fever
12. Hay Fever
13. Depression
14. Anxiety
15. Drug or Alcohol Abuse
16. Tuberculosis
17. Peptic Ulcer Disease
18. Hepatitis
19. Thyroid Disease_____
20. Chronic Kidney Disease
21. Gall Bladder Disease
22. GERD
23. BPH
24. Gout
25. Arthritis
26. Low Back Pain
27. Anemia
28. STDs_____
29. Seizure Disorder

Past medical history not listed: _____

List Past Surgical History: _____

_____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had any of the following?

Illness **Please list Family Member Relationship and Age when Diagnosed**

Cancer (Type): _____ Drug or Alcohol addiction: _____

Hypertension: _____ Glaucoma: _____

Heart Disease: _____ Bleeding Disorder: _____

Diabetes: _____ Osteoporosis: _____

Strokes: _____ Mental Illness: _____

Other: _____