Patient Registration

PATIENT INFORMATION:

Last Name: _____First Name: _____
Middle Initial: ____
Mailing Address _____ City: _____ State: _____
Zip:_____
Phone Number: Home_____ Cell_____
Work _____
Date of Birth: _____ Gender: M F
Social Security #: _____ Marital Status: _____
Race: _____ Ethnicity: _____
Email address: _____

PATIENT EMPLOYER INFORMATION

Name of Company: _____
Phone Number: _____
Street Address: _____ City: _____
State: _____ Zip: _____

INSURANCE POLICY HOLDER INFORMATION

Primary

Insurance: _____ Subscriber ID#:
_____ Group#: _____
Last Name: _____ First Name:
_____ Middle Initial: ____
Date of Birth: _____ Gender: M F Social Security #:
_____ Marital Status: _____
Relationship to the Patient: _____

Secondary

Insurance: _____ Subscriber ID#:
_____ Group#: _____Last Name:
_____ First Name: _____
Middle Initial: ____Date of Birth: _____ Gender: M F
Social Security #: _____ Marital Status: _____

* Emergency Contact: _____
Phone #: _____

How did you hear about us (circle one):
family newspaper mail out / flyer television employee
internet drive by billboard / sign friend referring physician
walk in yellow pages referred by employer patient school nurse

I certify that the information provided above is complete and accurate to the best of my knowledge.

_____ _____

Signature of Patient or Patient Representative Date

ADULT HEALTH HISTORY QUESTIONNAIRE

CONFIDENTIAL

PAST ILLNESSES

Please check any illnesses you have had.

_____ Asthma
_____ Hay fever
_____ Emphysema
_____ TB
_____ Kidney Trouble
_____ High blood pressure
_____ Rheumatic fever
_____ Diabetes
_____ Stroke
_____ Cancer _____
_____ Anemia (type)
_____ Arthritis
_____ Gout
_____ Abnormal Pap smear
_____ Stomach Ulcer
_____ Mental illness
_____ Seizures
_____ Depression
_____ Back trouble
_____ Bowel trouble
_____ Thyroid disease
_____ Glaucoma
_____ Gallstones
_____ Hepatitis
_____ Liver problems
_____ Bleeding problems
_____ Skin problems
_____ Alcohol problem
_____ Drug addiction
_____ Hearing loss
_____ Polyps of bowel
_____ Sexually transmitted disease
_____ HIV
_____ Other:_____

MEDICATIONS/ALLERGIES

List current medications you take and/or allergies you have:

Medications:

_____
_____
_____
_____
_____
_____

Allergies:

_____

WOMEN ONLY

Age at 1st menstrual period____
# of times pregnant ____
# of living children ____
Date of last Pap smear ____
Age when periods stopped ____
Birth control method:

_____

MEN & WOMEN

Do you consider yourself to be:
___heterosexual (straight)
___homosexual (lesbian/gay)
___bisexual

HOSPITALIZATIONS/SURGERIES INJURIES

Please list any hospitalizations, surgeries, &/or injuries you have had:

_____
_____
_____

FAMILY HISTORY

Please circle any diseases your parents, grandparents, brothers, sisters, aunts, or uncles have had:

Diabetes Asthma Stroke Cancer (type)_____
Alcoholism Seizures Heart Attack High Blood Pressure
Other:_____

NAME: _____ **DATE OF BIRTH:** _____