NERSISSIAN HEALTH MANAGEMENT GROUP

PATIENT REGISTRATION FORM

Date:

LAST NAME:			FIRST NAME:		
STREET ADDRESS		CITY		STATE	ZIP
SEX M F	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -	HOME TELEPHONE NUMBER: ( )		
MARITAL STATUS:			CELL PHONE: ( )		
DATE OF INJURY: / /					
E-MAIL ADDRESS:					
EMERGENCY NOTIFICATION Tel. No.: ( )	NAME AND RELATIONSHIP:				

OCCUPATION:		
How did you hear about us? (TV, Google/Yelp/internet, friend/family, radio)		
Referred by other Doctor/ Therapist/ Urgent Care/ER? (name)		

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS ON MY BEHALF.

MEDI-CAL: ☐ MEDICARE: ☐ PRIVATE INSURANCE: ☐ PERSONAL INJURY: ☐ HOMECARE: ☐ HOSPICE: ☐ TOURIST: ☐	______________________ PATIENT SIGNATURE __________ DATE

NEW PATIENT INTAKE FORM
Review of Systems/Past personal, family and social History

Name:________________________________ Age:_____ Sex:_______ Height:_________ Weight:____________
Occupation:_____________________________________ Family Physician:_____________________________
Who referred you to us?____

Reason for appointment:____ side: Right Left Both_________

MAJOR EVENTS

Please list all surgical operations (Type and Dates):

_______________________________________ ____
_______________________________________ ____
_______________________________________ ____

Please List any other serious illnesses or injuries:

_______________________________________ ____
_______________________________________ ____

MEDICATION ALLERGIES? No □ Yes □ **(medication name)**_____________________________________
Are you taking blood thinners? No □ Yes □ **(medication name)**___________________________________

ONGOING MEDICAL PROBLEMS

Do you have or have you had any of the following conditions?

Condition		Condition	
Anemia	Yes □ No □	Liver Disease	Yes □ No □
Anxiety	Yes □ No □	Neuropathy	Yes □ No □
Heart disease	Yes □ No □	Stroke	Yes □ No □
Diabetes	Yes □ No □	Ulcers	Yes □ No □
Elevated Cholesterol	Yes □ No □	Heart Attacks	Yes □ No □
High Blood Pressure	Yes □ No □	Congestive Heart failure	Yes □ No □
Cancer	Yes □ No □	Multiple Myeloma	Yes □ No □
Peripheral vascular disease	Yes □ No □	Abnormal Bleeding	Yes □ No □
Phlebitis	Yes □ No □	Pulmonary Embolism	Yes □ No □
Fibromyalgia	Yes □ No □	Thyroid disease	Yes □ No □
Osteoporosis	Yes □ No □	Respiratory problems	Yes □ No □
Vascular disease	Yes □ No □	Rheumatoid Arthritis	Yes □ No □
Drug Addiction	Yes □ No □	Kidney Problems	Yes □ No □

Do your parents or siblings have a history of any of the following conditions? If the answer is yes, please list the family member and relationship:

Stroke:_______________________________________ Diabetes:_______________________________
Arthritis:_____________________________________ Osteoporosis:____________________________
Hypertension:_________________________________ Heart Disease:___________________________
Bleeding problems:_____________________________ Malignant Hyperthermia:__________________
Cancer and type:____

Do you smoke? Yes □ No □ **Amount:**________________ **How Many years?**_________
Do you drink alcohol? Yes □ No □ **Amount:**____

Please list current medications/name and phone number of pharmacy -

____
____
____
____
____

Patient's Signature:____ **Date:**______________

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