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:		

EMPLOYER INFORMATION

EMPLOYER NAME:	WORK TEL. No.: ( )	OCCUPATION:
EMPLOYER ADDRESS:		
How did you hear about us? (TV, Yellow pages, friend/family, internet, radio)		
By whom were you referred? (Doctors name)		

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

A. MEDI-CAL: ☐
B. MEDICARE: ☐
C. PRIVATE INSURANCE: ☐
D. PERSONAL INJURY: ☐
D. WORKERS COMP: ☐

PATIENT SIGNATURE

DATE

1030 S. Glendale Ave. #507. Glendale, CA 91205 • Tel.: (818) 548-4668 • Fax: (818) 548-8863

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:_____

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?

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:**_____

1030 S. Glendale Ave. #507. Glendale, CA 91205 • Tel.: (818) 548-4668 • Fax: (818) 548-8863