PATIENT REGISTRATION INFORMATION

Name: _____ Date of Birth: _____ Social Security #: _____

Marital Status: M___S___W___D___Sep___ Sex: M___F___Other (Please Specify)_____

Race: _____ Ethnicity: _____ Preferred Language: _____ Full Time student? Yes___No_____

Home Address: _____City: _____ State: _____ Zip: _____

Home Phone _____Work/Daytime Phone: _____Email: _____

Name of Employer: _____Occupation_____

Address of Employer:_____

Preferred Pharmacy _____Pharmacy Phone _____

Address_____State_____Zip_____

How did you hear about us? _____Friend _____Newspaper _____Radio _____Billboard _____Other

OTHER REGISTRATION INFORMATION

If married:

Name of Spouse_____Social Security #_____Date of Birth_____

Name of Employer_____Occupation_____

Address of Employer_____

If a child:

Father's Name_____Social Security #_____Date of Birth_____

Mother's Name_____Social Security #_____Date of Birth_____

Father's Employer_____Work/Daytime Phone (_____)_____

Address of Employer_____Occupation_____

Mother's Employer_____Work/Daytime Phone (_____)_____

Address of Employer_____Occupation_____

CLOSEST RELATIVE OR FRIEND IN CASE OF EMERGENCY

Name:_____ Relationship to Patient_____

Address: Street_____Phone: _____

City_____State_____Zip_____

HEALTH INSURANCE INFORMATION

INSURED: Name _____Relationship to Patient _____

Marital Status: M___S___W___D___Sep___ Social Security #_____Date of Birth _____

Insured's Address_____

City_____State_____ Zip_____

Home Phone (_____)_____Work/Daytime Phone (_____)_____

Name of Insurance:_____Telephone #:_____

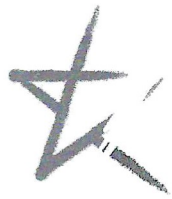
Claims Address: _____

Effective date_____Group # _____Certificate # _____

Name of Employer Group_____Primary Care Physician_____

Do you have other insurance? If yes, please provide information_____

Signature: _____ Date: _____



Confidential Health Questionnaire

Patient Name:_____DOB:_____Today's Date:_____

Please mark with a (✓) any of the following illnesses and medical problems you have or have had and indicate the year when each started.

ILLNESS

- ☐ Vision Loss/Blindness_____
- ☐ Glaucoma_____
- ☐ Cataracts_____
- ☐ Hearing Loss or Ear Problems_____
- ☐ COPD or Emphysema_____
- ☐ Pneumonia_____
- ☐ Seasonal Allergies_____
- ☐ Asthma_____
- ☐ Tuberculosis_____
- ☐ Other Lung Problems_____
- ☐ Vascular Disease (plaque in arteries)_____
- ☐ Heart Murmur_____
- ☐ Heart Disease_____
- ☐ High Cholesterol_____
- ☐ High Blood Pressure_____
- ☐ Other Heart Conditions_____
- ☐ Hernia_____
- ☐ Hemorrhoids_____
- ☐ Anemia_____
- ☐ Cancers _____
- ☐ Other Health Problems _____

- ☐ Stomach/Duodenal Ulcer_____
- ☐ Colitis or Diverticulosis_____
- ☐ Liver disease or Hepatitis_____
- ☐ Stroke or TIA_____
- ☐ Seizures_____
- ☐ Depression or Anxiety_____
- ☐ Headaches_____
- ☐ Dementia or Memory Loss_____
- ☐ Arthritis or Gout_____
- ☐ Thyroid Nodules_____
- ☐ Hypo or Hyperthyroid_____
- ☐ Diabetes _____
- ☐ Diabetic Nerve Pain/Numbness_____
- ☐ Diabetic Foot Infections_____
- ☐ Diabetic Eye Disease _____
- ☐ Amputation(s)_____
- ☐ Kidney Disease_____
- ☐ Recurrent Bladder Infections_____
- ☐ Bladder Incontinence_____
- ☐ Other Kidney problems_____

MALES ONLY:

- ☐ Prostate Enlarged or Cancer_____
- ☐ Impotence or Erectile Dysfunction_____

FEMALES ONLY:

- ☐ Gynecological/Obstetrical_____
- ☐ Breast Problems_____

Cancer Screenings and Routine Health Maintenance:

Females Only:

Last PAP_____ Last Mammogram_____

Last Pelvic exam_____

MEN and **WOMEN** Colon Cancer Screening with stool cards **OR** colonoscopy (date)_____

Please list name of physician who performed Colonoscopy_____

(Over)

VACCINES: (Year) Tetanus:_____ Pneumonia:_____ Zostavax (Shingles):_____Flu:_____

Last Primary Physician name/address/number:_____

Please sign a release today for these records* _____

Please list all Specialists you currently see: _____

_____

_____

Please list all times you have been hospitalized, operated on, or injured.

Year	Operation, Illness or Injury	Hospital and City
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications: _____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES _____ _____

Non-prescription drugs or supplements:_____

_____

Smoking or Tobacco products: Packs per day_____Years_____ Quit date:_____

Alcohol drinks per day or month:_____ Drug use:_____

Sexual Orientation:_____

Your Family's Health History

	Age if Living	Age at Death	Did/Do they have High Blood Pressure, Heart Disease, Strokes, Cancers or Diabetes?	State of health or Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
Spouse	_____	_____	_____	_____
Children	_____	_____	_____	_____

Do you have an **Advanced Directive** or **Living Will**? _____

Do you have a **Medical Power of Attorney**? _____ Who is it?_____

Patient Signature _____ Date _____

Name/Relationship of Individual Completing Form (if other than patient) _____

Notice of Privacy Practices & Communication Consent Form

Patient Name: _____ Date of Birth: _____

I have received a copy of Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Date

The patient or personal representative received a Notice of Privacy Practices but refused to sign above. After a good faith effort to obtain this acknowledgement I was unable to because:

_____

_____

_____ _____ _____
Printed Name of Associate Signature of Associate Date

Communication Consent Form

This communication may include any of the following:

- Appointment information/directions/reminders
- Recommendation for follow-up
- General educational/treatment information
- Financial/billing information such as invoices and receipts
- Wellness Report
- Treatment summary for insurance purposes
- Test result data
- Specific treatment information
- Medication list

By acknowledging and signing this consent form, you are granting permission to contact you on the mobile and/or land line number(s) listed below. Please note that contacts may be made as a direct dial call or through the use of text messages, pre-recorded or artificial voice messages, and/or the use of an automated telephone dialing system or auto-dialer. In addition, depending on your mobile service plan, message and data rates may be assessed by your mobile provider.

You may withdraw consent or opt-out at any time by providing written notice

Patient Signature _____ Patient Email Address _____

Patient (Print Name) _____ Patient Phone Number _____

Patient Cell Number _____ Date _____ / _____ / _____

If patient under 18 years of age, Parent/Guardian Signature _____

Parent/Guardian (Print Name) _____

[1] Be advised that email, telephone voice mail and text communications are not secure and may be intercepted or disclosed to third parties.