

Health to Home Medical Services New Patient Demographics

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
 Address: _____ City: _____
 State: _____ Zip Code: _____ Home Phone Number: _____
 Cell Phone Number: _____ How did you hear about us?: _____
 Email: _____ Consent to text message: YES NO

EMERGENCY CONTACT / GUARANTOR INFO

In the event of an EMERGENCY, please contact:

(1.) Name: _____ Relationship: _____

Home Phone Number: _____ Cell Phone Number: _____

Guarantor's Name: _____

Address: _____

First
M.I
Last

Street Address
City
State
Zip Code

Guarantor's Relationship to Patient: _____

INSURANCE

Primary

Insurance Name: _____ Member ID: _____

****Please turn your insurance card over and locate the address on the back of your card****

Claim Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Phone Number: _____

Secondary

Insurance Name: _____ Member ID: _____

****Please turn your insurance card over and locate the address on the back of your card****

Claim Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Phone Number: _____

Prescription Drug Coverage:

Name of Prescription Drug Coverage: _____

Policy Number: _____ BIN: _____ PCN: _____

GROUP: _____

Health to Home Medical Services

New Patient Registration Form

Thank you for taking the time to provide this valuable information. This knowledge allows us the ability to provide the best care possible. Please use additional pages to provide pertinent information.

Patient Name: _____ O Male O Female Birth Date: _____

Name of person filling out form: _____ Relationship: _____

Main reason for visit: _____ Date: _____

#1: CURRENT/PAST MEDICAL ISSUES

(Examples include strokes, heart trouble, high blood pressure, high cholesterol, thyroid problems, eye issues, etc.)

Current or Past Medical Issue	Date of Diagnosis

#2: PAST SURGERIES

(Examples include gall bladder removal, appendectomy, hysterectomy with or without ovary removal, cataract surgery, prostate surgery, heart surgery, angioplasty, colonoscopy, hip surgery, etc.)

Past Surgery	Date of Surgery

#3: MEDICAL ALLERGIES AND REACTIONS

(Examples include rash, swelling, trouble breathing, etc.)

Medicine/Substance Allergic To	Reaction

#4: MEDICATIONS: list both prescription and over-the-counter medication(s)

(Examples include pain relievers, laxatives, heart burn medication, vitamins, etc. Include how many times per day the medication is taken. For "as needed" medication provide an estimate of how often it is taken whether daily, every other day, once per week, etc.)

Name of Medication	Medication Strength (mg, mcg, etc.)	Frequency (How often?)

#5: PHARMACY INFORMATION

Pharmacy Name: _____ Phone # _____

Mail Order Pharmacy Name: _____ Phone # _____

Member ID # _____ Fax # _____

#6: FAMILY HISTORY: list medical problems of close family members

(Examples include dementia, type of cancer, heart disease, stroke, diabetes, hypertension, depression, etc. If deceased, include the age they past away. Use blank lines to include additional family members.)

Family Member	Alive/Deceased	Age	Medical Problems or Cause of Death
Father			
Mother			
Brother			
Sister			

#7: SOCIAL HISTORY

Tobacco Use:

Never
 Quit (Date: _____)
 Current Smoker
Packs per Day _____
Years Smoked _____
Type: Cigarette Cigar Pipe

Smokeless Tobacco Use:

Never
 Quit (Date: _____)
 Current User
Type _____

Alcohol Use:

None
 # Drinks/week: _____
Was drinking too much ever a problem: Yes No

Recreational Drug Use :

No
 Yes
Type _____

Sexually Active: Yes No

Firearms: Do you have firearms in the home? YES NO
If yes, are they locked and secured? YES NO

Communication Preference: English Other _____
Able to understand and read English language: Yes No

Religion/Faith: _____
 Yes No Is your faith important to you?
 Yes No Does your faith affect health care decisions?

Finances:

Yes No Durable Power of Attorney for Finance
Name/Relationship: _____
 Yes No Are you having trouble paying your bills?
 Yes No Are you going without food/medication?
 Yes No Are you going without personal items?
Past Occupation: _____
Years of Education: _____
Who helps care for patient? _____
Something patient is proud of in their lifetime: _____

#9: ABILITY TO DO ACTIVITIES

Activity	No Assist	Total Assist	Partial Assist: Describe
Feeding			
Bathing			
Toileting			
Dressing			
Transferring			
Walking			
Housework			
Meal Preparation			
Manage Money			
Use Telephone			
Other:			

#8: ADVANCE DIRECTIVES (attach copy of document)

Yes No Durable Power of Attorney for Healthcare
Name/Relationship: _____
 Yes No Living Will
 Yes No Do Not Resuscitate Form
 Yes No Would like more info on Advance Directives

#10: CAREGIVER QUESTIONS Caregiving can be both rewarding and challenging. Please let us know the following:

Do you feel you are able to provide the care your relative needs: Yes No

Comment: _____

Do you feel you have time to take care of yourself? Yes No

Comment: _____

#11: REVIEW OF SYSTEMS *Check or describe any symptoms you are experiencing*

General	Skin	Head	Eyes
<input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Fatigues <input type="checkbox"/> Sweating <input type="checkbox"/> Weakness Height: _____ Height loss? _____ in. Weight: _____ Weight loss? _____ lbs in _____ months	<input type="checkbox"/> Rash Location _____ <input type="checkbox"/> Itching <input type="checkbox"/> Bed sore Location _____ Dressing type _____	<input type="checkbox"/> Headaches <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hearing aid <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Nose congestion <input type="checkbox"/> Sore throat <input type="checkbox"/> Date of last dental exam _____	<input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye discharge <input type="checkbox"/> Eye redness <input type="checkbox"/> Date of last eye exam _____
Heart	Lungs	Gastrointestinal	Genitourinary
<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg cramps <input type="checkbox"/> Leg swelling <input type="checkbox"/> Trouble breathing while laying flat	<input type="checkbox"/> Cough <input type="checkbox"/> Sputum production <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> On oxygen <input type="checkbox"/> Oxygen flow rate _____	<input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stool	<input type="checkbox"/> Urinary burning <input type="checkbox"/> Urgency <input type="checkbox"/> Frequency <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence
Musculoskeletal	Endocrine	Neurological	Psychiatric
<input type="checkbox"/> Muscle aches <input type="checkbox"/> Neck pain <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Low-back pain <input type="checkbox"/> Joint pain Location _____ <input type="checkbox"/> Fall within the past year <input type="checkbox"/> Pain intensity (10=severe) 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> Easy bruising <input type="checkbox"/> Environmental allergies <input type="checkbox"/> Extreme thirst <input type="checkbox"/> Diabetic Morning sugar range: _____ Evening sugar range: _____	<input type="checkbox"/> Dizziness <input type="checkbox"/> Tingling <input type="checkbox"/> Tremor <input type="checkbox"/> Sensory change <input type="checkbox"/> Speech change <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Seizures <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Weakness on one side of body from stroke: Right or Left	<input type="checkbox"/> Depression <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Substance abuse <input type="checkbox"/> Hallucinations <input type="checkbox"/> Nervous/Anxious <input type="checkbox"/> Insomnia <input type="checkbox"/> Memory loss

Over the past two (2) weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things? Not At All Several Days More Than Half of the Days Nearly Every Day
- Feeling down, depressed or hopeless? Not At All Several Days More Than Half of the Days Nearly Every Day

#12: IMMUNIZATIONS

(Please contact your primary care provider if you are uncertain regarding immunizations received prior to our visit)

Immunization	Date Received
Influenza (Flu)	
Pneumovax (Pneumonia)	
Pprevnar (Pneumonia)	
Tdap (Tetanus)	
Zostavax (Shingles)	

#13: DURABLE MEDICAL EQUIPMENT

(List any medical equipment utilized such as bedside commode, wheelchair, walker, hospital bed, tube feeding pump, etc.)

Equipment	Supplier Name and Phone

#14: RECENT HOSPITALIZATIONS

(List all hospitalizations within the past two (2) years)

Reason	Hospital	Date

#15: RECENT DOCTOR VISITS

(List any recent doctors seen, their specialties (i.e. primary, cardiologist, neurologist, etc.) and their phone number)

Name	Specialty	Phone

#16: HOME HEALTH/HOSPICE AGENCY INFORMATION

Agency Name: _____

Phone: _____

- Nurse Yes No Physical Therapy Yes No
 Aide Yes No Speech Therapy Yes No

Occupational Therapy Yes No