Midwest Health Center-St. Louis

Date: _____

PATIENT REGISTRATION

PATIENT INFORMATION-PLEASE PRINT AND COMPLETE ALL FIELDS

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SOCIAL SECURITY #	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	PATIENT EMAIL ADDRESS	

RESPONSIBLE PARTY INFORMATION (If Patient is a Minor) RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

CURRENT MEDICAL PROVIDERS

PRIMARY CARE DOCTOR/FAMILY DOCTOR	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
DO YOU HAVE A SPECIALIST THAT YOU SEE ? ☐Yes ☐No	NAME & MED. SPECIALTY	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
SECONDARY SPECIALIST NAME/SPECIALTY	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
DO YOU HAVE A MENTAL HEALTH PROVIDER OR THERAPIST YOU SEE ? ☐Yes ☐No	NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE

IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

PRIVACY POLICY ACKNOWLEDGEMENT: I hereby acknowledge that I have been provided a copy of Midwest Health Center-St Louis / David Greengart, MD's "NOTICE OF PRIVACY PRACTICES".

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE
X	

AUTHORIZATION TO RELEASE HEALTH INFORMATION:

Information about my healthcare may be released to (Name):	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	EXPIRATION: UNLESS OTHERWISE NOTED, AUTHORIZATION WILL REMAIN IN EFFECT INDEFINITELY		

Release the following information:

❑ All Records ❑ Chart Notes ❑ Radiology Reports ❑ Laboratory Test Results ❑ History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
X		
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

Midwest Health Center-St. Louis

Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

***** Preferred Pharmacy:** **Phone Number:**

Allergies

- ❑ NONE/No Known Allergies
- ❑ Adhesive Tape
- ❑ Anesthesia
- ❑ Aspirin
- ❑ Codeine
- ❑ Dairy Products
- ❑ Iodine/Shellfish/Contrast Dye
- ❑ Latex
- ❑ Morphine
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ Wheat

OTHER (Please List):

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Arthritis			
Breathing Problems			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

Do you currently use tobacco? ☐Yes ☐No ☐ Smoke (___ packs per day) ☐ Chew

Do you drink alcohol? ☐Yes ☐No ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

Drug Use (please list all you have EVER used): ☐Oxycodone ☐Hydrocodone ☐Tramadol ☐Heroin ☐Dilaudid ☐Morphine ☐Cocaine ☐Methamphetamines ☐Marijuana ☐Benzodiazepines(Xanax,Klonopin,etc) ☐Other (Please List)_____

Route of Drug Use (Check all that apply) ☐ IV ☐ Smoke/Snort ☐Ingest ☐Other (specify) _____

Have you ever had a drug overdose? ☐ Yes ☐ No If Yes, Please Specify: ☐ Unintentional ☐ Intentional

Have you ever been to drug rehab? ☐ Yes ☐ No If so, when most recently?_____ ☐ Inpatient ☐ Outpatient

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ❑ NONE of the problems listed
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma/COPD
- ❑ Atrial Fibrillation
- ❑ Biploar Disorder
- ❑ Bleeding Problems
- ❑ Breathing Problems
- ❑ Cardiac Stents
- ❑ Coronary Artery Disease
- ❑ Cancer
- ❑ Cardiac Arrest
- ❑ Congestive Heart Failure (CHF)
- ❑ Chronic Fatigue Syndrome
- ❑ Chronic Pain
- ❑ Depression/Anxiety
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Infection Problems
- ❑ Insomnia
- ❑ Irritable Bowel Syndrome
- ❑ Kidney Problems
- ❑ Migraines/Headaches
- ❑ Neuropathy
- ❑ Pulmonary Embolism/Blood Clots
- ❑ Seizure
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems

OTHER (Please List):

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR