Welcome

PATIENT REGISTRATION INFORMATION

Date _____ Soc. Sec. # LAST 4 NUMBERS _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE (IF APPLICABLE)

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to DR. CHRISTNACHT for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

COMPLETE
HISTORY AND PHYSICAL

Name: _____ Age: _____ Date: / /

BP, P, RR, T, WT: _____ ☐HMO Copay $ _____

Insurance Co. _____ ☐PPO Copay $ _____

Mail Claim To _____ Policy No. _____

Chief Complaint And Present Illness

Past History/ Childhood Illnesses (Answer Yes Or No)

_____ Chicken Pox	_____ Whooping Cough	_____ Pneumonia
_____ Mumps	_____ Scarlet or Rheumatic Fever	_____ Heart Murmur
_____ Measles	_____ Kidney Disease (If yes, specify)	_____ Mononucleosis
_____ Diphtheria	_____	_____ Other

Any Operations/Hospitalizations? **Date** **Place**

1.
2.
3.
4.
5.
6.

Any Transfusions? No Yes When

Any Accidents Requiring Hospitalizations? **Date** **Place**

1.
2.
3.
4.
5.
6.
7.

Any Serious Illness As An Adult? **Date** **Place**

1.
2.
3.
4.
5.

Any Chronic Infectious Disease? **Date** **Place**

1.
2.
3.
4.

Any Emotional Or Mental Illness? **Date** **Place**

1.
2.

COMPLETE
HISTORY AND PHYSICAL

Date: / /

Name:

Medicine Or Pills Taken? (List all, even vitamins and aspirin)

Name or Type	Year Begun	Year Stopped	Check Effects: Helped	Check Effects: No Help	Side Effects
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

IMMUNIZATIONS? Answer Yes or No in _____, and place date in ( ).

_____ DPT (Tetanus) ( ) _____ Mumps ( ) _____ Pneumococcal Vac. ( )

_____ Polio ( ) _____ Rubella ( ) _____ Other ( )

_____ Measles ( ) _____ "Flu" Vaccine ( )

Any Allergies To Medicines? **What Effects?**

1.
2.
3.
4.

Any Allergies To Foods Or Other? **What Effects?**

1.
2.
3.
4.

Family History:

	Health: Good	Poor	Died	Age	Cause Of Death
Father					
Mother					
Brothers 1.					
2.					
3.					
4.					
Sisters 1.					
2.					
3.					
4.					

Do Any Blood Relatives Have The Following?

Problem	Relation	Problem	Relation	Problem	Relation
Migraine		Emphysema		Thyroid Disease	
Epilepsy		Lung Disease		Overweight	
Stroke		Asthma		Infectious Disease	
Glaucoma		Stomach Ulcers		Allergies	
Hearing Loss		Gallstones		Anemia	
Rheumatic Fever		Kidney Disease		Gout	
Heart Murmur		Nephritis		Bleeding Tendency	
Heart Disease		Arthritis		Mental Illness	
High Blood Pressure		Diabetes		Other:	
Tuberculosis		Cancer			

Social History:

		Position Held	Nature or Description of Work	# Of Years
Occupation	Previous	1.		
		2.		
	Present	3.		

Any Exposure To Toxic Or Dangerous Materials?

	No	Yes	When	Name or Type	What Symptoms?	Other People Affected?
Insulation						
Fumes						
Metals						
Chemicals						
Plastics						
Solvents						
Dyes						
Animals						
Other:						

Foreign Travel (Past 10 years)

1. _____ When? _____
2. _____ When? _____
3. _____ When? _____
4. _____ When? _____

Hiv Risk Factor? _____

Pets: Cats _____ Dogs _____ Other _____

Single _____ **Divorced** _____ When? _____ **Long Term Partner** _____

Married _____ When? _____ **Widowed** _____ When? _____

Children: Boys _____ Girls _____

Social Habits	No	Yes	When Started	When Stopped	Amount
Smoke					Packs Per Day _____
Coffee					Cups Per Day _____
Alcohol					Liquor/day _____ Beer/day _____ Wine/day _____
Other Drugs					

Meals: Regular? Yes _____ No _____ Meals Per Day _____ Snacks Per Day _____

Emotional Stress:
- At Work _____
- Family _____
- Other _____

Exercise:
- None _____
- Irregular _____ Type? _____ # Of Times/week _____
- Regular _____ Type? _____ # Of Times/week _____

Sleep: Regular? Yes _____ No _____ Hours Per Night _____ Do You Snore? _____ Yes _____ No _____

Other relevant information that may have bearing on your lifestyle and health, in your own words:

Medical Alert _____

Name: _____

Review Of Systems

Pt. Initials:

Problem	No	Yes	Date Began	
Convulsion, Seizure			/ /	
Frequent Headaches			/ /	
Dizzy, Balance Problem			/ /	
Fainting			/ /	
Wear Glasses, Contacts			/ /	
Vision Worse			/ /	
Eye Pain			/ /	
Frequent Earaches			/ /	
Decreased Hearing			/ /	
Sinus Pains			/ /	
Often Stuffy Nose, Sneezing			/ /	
Difficulty Swallowing/Sore			/ /	
High Blood Pressure			/ /	
Chest Pain at Rest			/ /	
Chest Pain Exercising			/ /	
Heart "Races"			/ /	
Heart "Skips Beats"			/ /	
Heart Murmur			/ /	
Short of Breath [At Night			/ /	
Short of Breath [At Rest			/ /	
Short of Breath [Exercising			/ /	
Swelling Feet, Ankles			/ /	
Frequent Cough			/ /	
Coughed Up Blood			/ /	
Bronchitis			/ /	
Pneumonia			/ /	
Pleurisy			/ /	
Asthma Or Wheezing			/ /	
Emphysema			/ /	
Abdominal Pain			/ /	
Frequent Nausea			/ /	
Vomiting Blood			/ /	
Bloody or Black Stools			/ /	
Frequent Diarrhea			/ /	
Frequent Constipation			/ /	
Hepatitis Or Jaundice			/ /	
Cirrhosis Of Liver			/ /	
Pancreatitis			/ /	
Pain On Urination			/ /	
Blood in Urine			/ /	