REGISTRATION INFORMATION

Date:________________ (PLEASE PRINT) Home Phone:________________

Patient:________________ Last Name ________________ First Name ________________ Initial

Responsible Party (if a minor):________________

Street Address:________________

City:________________ State:________________ Zip:________________

Sex: ☐ M ☐ F Age________ Birthdate________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By:________________

Business Address:________________

Occupation:________________ Business Phone:________________

Spouse (or responsible party) Employed By:________________

Business Address:________________

Occupation:________________ Business Phone:________________

Purpose of Visit:________________

Who is responsible for this account?________________ Relationship to Patient________________

Social Security #________________ Spouse's Social Security #________________

Do you have Medical Insurance? ☐ No ☐ Yes ► If yes,

Name of Primary Insurer________________

Contract #________________ Group #________________ Subscriber #________________

Name of Secondary Insurer (if any)________________

Contract #________________ Group #________________ Subscriber #________________

☐ Medicare ☐ Medicaid Claim ID #________________

If Welfare, your number________________ County of________________

I prefer, to: ☐ Pay my balance in full at time of service. ☐ Pay my balance in full upon receipt of first statement.
☐ Make payment arrangements prior to services being rendered.

In case of emergency, who should be notified?________________ Phone:________________

Your Drugstore Name:________________ Phone:________________

How did you learn of our practice?________________

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I________________ (Name of Insured) hereby authorize________________ (Name of Insurance Company)

to pay and hereby assign directly to________________ (Provider's Name) all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to________________ (Provider's Name), will be credited to my account, in accordance with the above said assignment.

________________ (Authorized Signature of Subscriber) ________________ (Date)

Medical History

Date: / /

Name ______________________ Age ____________ Birthdate ___/___/___

Address ______________________ Sex: ❑ M ❑ F

______________________ Home Phone ______________________

______________________ Work Phone ______________________

Occupation ______________________ Emergency contact ______________________

Phone ______________________

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If married, spouse's name ______________________

Children's names and ages ______________________

Allergies to Medications, X-Ray Dyes, or Other Substances ❑ No ❑ Yes

(If yes please list name of medicine and type of reaction):

______________________ ______________________ ______________________ ______________________

______________________ ______________________ ______________________ ______________________

______________________ ______________________ ______________________ ______________________

______________________ ______________________ ______________________ ______________________

Past Medical History and Review of Systems

Please circle if you have had problems with or are presently experiencing any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Light-headedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32 Thyroid Disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin Diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol Abuse
47. Drug abuse
48. Gout
49. ______________
50. ______________

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Gynecologic and Obstetric History

Age at onset of periods: ____________ Frequency: ____________ Length of period: ____________

Pregnancies: ____________ Births: ____________ Miscarriages: ____________

Prolonged or abnormal bleeding: ❑ No ❑ Yes (Please describe): ______________________

Leakage of urine: ❑ No ❑ Yes (Please describe): ______________________

Pelvic pain: ❑ No ❑ Yes (Please describe): ______________________

Abnormal discharge: ❑ No ❑ Yes (Please describe): ______________________

History of abnormal Pap smear: ❑ No ❑ Yes (Please describe): ______________________

This information is for use by your physician as part of your confidential medical records.

Please continue on next page

Patient Name **Date** / /

Please List and Supply the Dates of:

Operations ____________ ____________ ____________

____________ ____________ ____________

Hospitalizations other than for surgery: ____________ ____________

____________ ____________ ____________

Immunization history - have you had:

Hepatitis B? ❑ No ❑ Yes When? ______

Other?______ ❑ No ❑ Yes When? ______

Pneumovax immunization? ❑ No ❑ Yes When? ______

Flu immunization? ❑ No ❑ Yes When? ______

Tetanus immunization? ❑ No ❑ Yes When? ______

When was you last:

Pap Smear? ____________ Breast Exam? ____________ Stool check for blood? ____________

Mammogram? ____________ Cholesterol Check? ____________ Prostate exam? ____________

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. Age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, ect.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other: ______		

Medications (Prescriptions, Over the Counter, Vitamins, Herbs, ect.)

Drug Name	Dose	Drug Name	Dose

Prevention

Do you wear seat belts? ❑ Yes ❑ No If no, why not? ____________

Do you wear a bike helmet? ❑ Yes ❑ No ❑ N/A

Do you exercise regularly? ❑ Yes ❑ No If yes, type, duration and number of times per week:

____

Do you smoke? ❑ Yes ❑ No If yes, how many packs per day? ____________

Do you drink alcoholic beverages? ❑ Yes ❑ No If, yes, how much per week? ____________

Do you drink coffee? ❑ Yes ❑ No If yes, how many cups per day? ____________

Do you drink tea? ❑ Yes ❑ No If yes, how many cups per day? ____________

If there is a gun in your home, do you keep it unloaded and out of childrens reach? ❑ Yes ❑ No ❑ N/A

Do you use drugs? (marijuana, cocaine, crack, ect.) ❑ Yes ❑ No If yes explain: ____________

Have you ever engaged in any activity which put you at the risk of getting AIDS? ❑ Yes ❑ No If yes explain: ____________

Do you wished to be tested for AIDS? ❑ Yes ❑ No

Have you ever worked with chemicals, paints asbestos, or other hazardous material? ❑ Yes ❑ No If yes explain: ____________

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ❑ Yes ❑ No

Do you ever fear your partner ❑ Yes ❑ No ❑ N/A

Do you have a "living will"? ❑ Yes ❑ No

Do you have a donor card? ❑ Yes ❑ No

Method of birth control? ____________

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