

**PATIENT REGISTRATION**

Name \_\_\_\_\_ SS# \_\_\_\_\_  
 Street Address \_\_\_\_\_ Date of birth \_\_\_\_\_ Marital status: S M W Sep D  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone: Home \_\_\_\_\_ Office \_\_\_\_\_  
 Referred by \_\_\_\_\_  
 Spouse's name \_\_\_\_\_  
 Spouse's employer / address \_\_\_\_\_  
 Emergency contact \_\_\_\_\_ Tel # \_\_\_\_\_ Relationship \_\_\_\_\_

**PATIENT EMPLOYER INFORMATION**

Employer name \_\_\_\_\_ Tel # \_\_\_\_\_  
 Employer street address \_\_\_\_\_ City / State \_\_\_\_\_  
 Patient's occupation \_\_\_\_\_

**INSURED PERSON (IF NOT PATIENT)**

Name \_\_\_\_\_ Tel # \_\_\_\_\_  
 Street address \_\_\_\_\_ City / State \_\_\_\_\_ Zip \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_

**INSURANCE**

Medicaid # (if applicable) \_\_\_\_\_ Medicare # (if applicable) \_\_\_\_\_  
 Primary Insurance Company Name \_\_\_\_\_  
 ID # \_\_\_\_\_ Group # \_\_\_\_\_ Tel # \_\_\_\_\_  
 Secondary Insurance Company Name \_\_\_\_\_  
 ID # \_\_\_\_\_ Group # \_\_\_\_\_ Tel # \_\_\_\_\_

**INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date \_\_\_\_\_ Signature \_\_\_\_\_

I hereby authorize Dr. \_\_\_\_\_ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. \_\_\_\_\_ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
(Patient, parent, or guardian)

PATIENT REGISTRATION

Name \_\_\_\_\_ SS# \_\_\_\_\_

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit \_\_\_\_\_

Present medications: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Allergies (e.g. itchiness or hives) to specific brands of soap/laundry detergent: \_\_\_\_\_

Other physicians currently treating you \_\_\_\_\_

Previous or other medical problems \_\_\_\_\_

List any previous surgeries or hospitalizations (include number of miscarriages and live births): \_\_\_\_\_

Females only: Are you pregnant, planning a pregnancy or nursing a child?  Yes  No

Do you smoke?  No  Yes  Cigarettes  Pipe  Cigars  No. of years \_\_\_\_ How much? \_\_\_\_

Interested in stopping?  Yes  No

Do you regularly drink alcohol?  Yes  No How many ounces/beers per day? \_\_\_\_\_

Do you regularly drink coffee?  Yes  No How many cups per day? \_\_\_\_\_

Are you under a lot of pressure at work?  Yes  No Please describe: \_\_\_\_\_

PERSONAL MEDICAL HISTORY

Have you ever had any of the following (check all that apply):

- Chest pain/pressure/tightening \_\_\_\_\_  Asthma \_\_\_\_\_  Kidney Disease \_\_\_\_\_
 Hypertension \_\_\_\_\_  Dizzy spells \_\_\_\_\_  Shortness of breath \_\_\_\_\_
 Heart attack \_\_\_\_\_  Cancer \_\_\_\_\_  TB/lung disorder \_\_\_\_\_
 Stroke \_\_\_\_\_  Diabetes \_\_\_\_\_  Ulcers \_\_\_\_\_
 Headaches \_\_\_\_\_  Arthritis \_\_\_\_\_  Skin disorders \_\_\_\_\_
 Glaucoma \_\_\_\_\_  Difficulty hearing \_\_\_\_\_  Hepatitis \_\_\_\_\_
 Allergies or Eczema \_\_\_\_\_  Glaucoma \_\_\_\_\_  Cataracts \_\_\_\_\_
 Depression \_\_\_\_\_  Memory loss \_\_\_\_\_  Digestive problems \_\_\_\_\_
 Blood in stool \_\_\_\_\_  Hemorrhoids \_\_\_\_\_  Frequent urinary infections \_\_\_\_\_
 Other \_\_\_\_\_

IMMUNIZATIONS

FAMILY HISTORY

(Year last received, if known)

Table with 8 columns: Immunization, Father, Mother, Father's Parents, Mother's Parents, Siblings, Children. Rows include Smallpox, Tetanus, Typhoid, Polio, Influenza, Pneumonia, Rubella, Hepatitis, High blood pressure, Epilepsy, Cancer, Eczema / Psoriasis, Heart Attack /Stroke, Diabetes, Asthma, Hay fever.