FROST FAMILY MEDICINE

REGISTRATION

Patient Information (Please Sign and return to Receptionist)

Last Name			First Name		Middle Initial	Date of Birth
Address			City		State	Zip
Home Phone	Day Phone	Cell Phone		E-mail		Driver's License #
Preferred Language		Race		Soc Sec #		
Gender: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Life Partner						
Preferred Method of Contact: ❑ Mail ❑ Phone ❑ Cell Phone						

Responsible Party (Parent or legal guardian who resides with patient)

Last Name			First Name		Middle Initial	Date of Birth
Address			City		State	Zip
Home Phone	Day Phone	Cell Phone	E-mail			Driver's License #
Gender: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Life Partner						
Relationship to patient:						

Emergency Contact (If different from responsible party)

Last Name			First Name		Middle Initial	Date of Birth
Address			City		State	Zip
Home Phone	Day Phone	Cell Phone	E-mail			
Relationship to patient:						

I/We do hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of Frost Family Medicine, Inc. which they may deem advisable. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical service for myself and my dependents regardless of insurance coverage, excluding only authorized covered services provided under a valid prepaid HMO contract.

I furthermore agree to pay legal interest, collection expense, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Frost Family Medicine, Inc. to release information requested by insurance company and/or its representative.

_______I fully understand this agreement and consent will continue until cancelled by me in writing.
Initial

_______I authorize MemorialCare Medical Group, Inc. to render necessary medical or surgical
Initial treatment to the above named minor or whom I am the parent or legal guardian.

SIGNATURE: ______________________________ DATE: ____________________

NAME (Please print): _________________________ RELATIONSHIP: _____________

Pharmacy Information

Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advance Directives

❑ None ❑ Do Not Resuscitate ❑ Durable Power of Attorney ❑ Living Will ❑ HC Proxy
Date Reviewed:

Medications

❑ I do not take any medications.

List all medications you take, prescription and nonprescription, and their dosage.

Medication Name	Dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Medication and Food Allergies

❑ No Known Allergies

List all known allergies (DRUGS, FOOD, ANIMALS, ETC):

1.
2.
3.
4.
5.
6.
7.
8.

Medical History

Please check if you have ever experienced any of the following conditions, and year of onset.

Condition	Year	Condition	Year
❑ None		❑ Gallbladder disease	
❑ Allergies		❑ GERD (Reflux)	
❑ Anemia		❑ Hepatitis C	
❑ Angina		❑ Hyperlipidemia	
❑ Anxiety		❑ Hypertension	
❑ Arthritis		❑ Irritable bowel disease	
❑ Asthma		❑ Liver disease	

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REGISTRATION

Medical History (continued)

Condition	Year	Condition	Year
❑ Atrial fibrillation		❑ Migraine headaches	
❑ Benign prostatic hypertrophy		❑ Myocardial infarction	
❑ Blood clots		❑ Osteoarthritis	
❑ Cancer Type:		❑ Osteoporosis	
❑ Cerebrovascular accident		❑ Peptic ulcer disease	
❑ Coronary artery disease		❑ Renal disease	
❑ COPD (Emphysema)		❑ Seizure disorder	
❑ Crohn's disease		❑ Thyroid disease	
❑ Depression		❑ Other	
❑ Diabetes		❑ Other	

Surgical History

Please check if you have had any of the following procedures, and provide year procedure was done.

Surgical procedure	Year	Surgical Procedure	Year
❑ None		**Men Only**	
❑ Angioplasty		❑ Prostate Biopsy	
❑ Angioplasty w/ stent		❑ TURP (Trans-Urethral Resection of the Prostate)	
❑ Appendectomy			
❑ Arthroscopy knee		❑ Vasectomy	
❑ Back surgery		❑	
❑ CABG (heart bypass)		❑	
❑ Carpal tunnel release			
❑ Cataract extraction		**Women Only**	
❑ Cholecystectomy		❑ Augmentation mammoplasty	
❑ Colectomy		❑ Bilateral tubal ligation	
❑ Colostomy		❑ Breast biopsy	
❑ Gastric bypass		❑ Cesarean section	
❑ Hernia repair		❑ D and C	
❑ Hip replacement		❑ Hysterectomy	
❑ Knee replacement		❑ Mastectomy	
❑ LASIK		❑ Myomectomy	
❑ Liver biopsy		❑ Reduction mammoplasty	
❑ Pacemaker		❑ TAH/BSO	
❑ Small bowel resection		❑ Vaginal hysterectomy	
❑ Thyroidectomy		❑	
❑ Tonsillectomy		❑	

Health Maintenance

Please check if you have had any of the following exams and provide the date of the last exam.

Exams	Date	Exams	Date
❑ None		❑ GYN exam	
❑ Breast Exam		❑ Influenza Vaccine	
❑ Cardiac Stress Test		❑ Lipid Panel	
❑ Colonoscopy		❑ Mammogram	
❑ DEXA Scan		❑ PAP Test	
❑ Echocardiogram		❑ Physical Exam	
❑ EKG		❑ Pneumococcal Vaccine	
❑ Eye Exam		❑ Pulmonary Function Test	
❑ FOBT(stool card for hidden blood)		❑ Sigmoidoscopy	
❑ Foot Exam		❑ Tetanus Vaccine	

Family History

Please check if any family member has had any of the following conditions.							❑ Adopted
Diagnosis	**Mother**	**Father**	**Sister**	**Brother**	**Other**	**Other**	**Other**
Alcoholism							
Allergies							
Alzheimer's disease							
Asthma							
Blood disease							
CAD (heart attack)							
Cancer/ Indicate Type:							
CVA (Stroke)							
Depression							
Developmental delay							
Diabetes							
Eczema							
Hearing deficiency							
Hyperlipidemia (high cholesterol)							
Hypertension (high blood pressure)							
Irritable bowel disease							
Learning disability							
Mental illness							
Tuberculosis							
Obesity							
Osteoarthritis							
Osteoporosis							
PVD							
Renal disease							
Other:							

Social History

For Adult Patient:

Do you have children? ❑Yes ❑No	How Many?	Female/s:	Male/s:

Tobacco Use:	❑Yes ❑No ❑Former, Year Quit:_______________________________________ Type: ❑Chewing ❑Pipe ❑Cigar ❑Cigarette ❑Smokeless, Brand:_________ Frequency: ❑ Daily ❑ Some days ❑ Not sure	
Alcohol Use:	❑ Never ❑Yes ❑No ❑ Former/Year Quit:___________________ Type: ❑ Beer ❑ Liquor ❑ Wine ❑ Other:___________________________________ Frequency: ❑ Daily ❑ Some days ❑ Not sure	
Exercise/Activity	Level: ❑ Moderate ❑ Sedentary ❑ Vigorous Frequency: ❑ Daily ❑ Some days ❑ Not sure	**Sleep Pattern:** Changes: ❑ Yes ❑ No
Caffeine Use:	❑ Never ❑ Yes ❑ No ❑ Former/Year Quit: Type: ❑ Chocolate ❑ Coffee ❑ Soda ❑ Tablets ❑ Tea ❑ Other:_____________ Frequency: ❑ Daily ❑ Some days ❑ Not sure	

For Pediatric Patient:

Patient Resides With:	Primary:	❑ Mother	❑ Father	❑ Both Parents	❑ Other:
	Secondary:	❑ Mother	❑ Father	❑ Other	

Parents Occupation: Mother:	Father:

Parents Relationship: ❑ Married ❑ Divorced ❑ Separated	Childcare:					
	Mother	Father	Sibling	Grandparent	Nanny	Daycare
Tobacco Exposure: ❑ Yes ❑ No Smokers at Home: ❑ Yes ❑ No	Current Smoker: ❑ Daily ❑ Some days ❑ Not sure ❑ Former/Year Quit:					

Family History