SANTA MARIA CLINIC PA

Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (☐ cell or ☐ work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M F Social Security Number: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient's Employer: _____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student ☐ Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): _____ Relationship to Patient: _____

I verify the accuracy of the above information and authorize the release of any information necessary to process my claim. I authorize payment of medical benefits to the named provider. Additionally, I understand if a referral or an authorization is required, and I do not provide one, I will be responsible for ALL open balances.

Patient / Parent or Guardian Signature: _____ Date: _____

SANTA MARIA CLINIC PA

HEALTH HISTORY

Personal Information Date:_____

Patient Name: _____ Birth Date: ____/____/____ Age: ____

Occupation _____ Marital Status: _____ Name of Partner/Spouse: _____

Race: ☐ Asian ☐ Black or African American ☐ Native American ☐ White / Caucasian

☐ Other: _____

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: _____

Number of children: _____ Children's Names/Ages: _____

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor: _____

_____

_____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

Preferred **Pharmacy**: _____

Date of Last Complete Physical Exam: _____ Date of Last Blood Work: _____

Date of Last Colonoscopy: _____ Date of Last Tetanus Shot: _____

For Females: Date of Last Menstrual Period: _____ Date of Last Pap Smear: _____

History of Abnormal Pap (list date/s)? _____ Date of Last: Mammogram: _____ DEXA: _____

Number of Pregnancies: _____ Miscarriages: _____ Terminations: _____ Living Children: _____

Method/s of Contraception: _____

If **YOU** or a **FAMILY MEMBER** has had any of the following, please circle and indicate which family member when applicable:

ADD/ADHD	Type 1 or 2 Diabetes	Respiratory Disease
Anemia	Fractures	Skin Disease
Allergies/Hay Fever	Gynecological Disease	Stomach/Colon Disease
Asthma	High Blood Pressure	Stroke
Arthritis	High Cholesterol	Seizure Disorder
Anxiety/Depression	Heart Attack	Thyroid Disorder
Alcoholism	Kidney Disease	Sexually Transmitted Disease
Blood Clots	Liver Disease	Other:
Cancer, Type/s	Neurological Disease	_____
_____	Osteopenia/Osteoporosis	
	_____	

Please list any **SURGERIES** you have had and include the month/year:

_____

_____

_____

_____

Social Information

Tobacco Use: Do you smoke? _____ If so, how many cigarettes/cigars per day: _____ No. of years smoking: _____ Do you chew tobacco? _____ Have you thought about quitting? _____ Have you quit before? ____ How long?____

Alcohol Use: Do you drink alcohol? ____ If so, what type? _____ How many in 1 week? _____

Drug Use: Any history of illegal drug use? _____ If so, what type/s? _____ When? _____

Do you **exercise**? _____ What activities do you do, and how often in 1 week?_____

_____

Are you on any special **diet**? _____ If so, what? _____

Do you consume any **caffeinated** products? _____ If so, what and how much per day? _____

Have you recently noticed an increase in sadness or gloominess? _____

Have you lost interest in enjoyable activities? _____

Do you have a living will? _____ If yes, please provide us a copy.