Patient Registration

OFICE USE ONLY

○ **New Patient**
C **Current Patient Update**

Please Complete All

Date	Acct. No

Patient Name Last First Initial					Marital Status ☐ S ☐M☐ W ☐D	Sex ☐ M ☐ F
Home Address	City State Zip				Home Telephone	
Employer/School	Employer/School Address				Work Telephone	
Occupation	Social Security	Driver's License No. State	D.O.B.	Age	Living Will	
Spouse or Parent Name	Employer's Address				Work Telephone	
Name of Financially Responsible Person (If Different From Patient)						
Address (If Different From Patient)	Home Telephone				Work Telephone	
Primary Health Insurance	Policy Holder				Policy Holder's Relationship To Patient: ☐ Self ☐Spouse ☐Parent Other☐	
Insurance Co. Address	ID/Policy No.	Group No.	Coverage Code	Effective Date		
Secondary Health Insurance	Policy Holder				Policy Holder's Relationship To Patient: ☐ Self ☐Spouse ☐Parent Other☐	
Insurance Co. Address	ID/Policy No.	Group No.	Coverage Code	Effective Date		
Family Physician	Referred By:	Address	Telephone			
Any Member of Family Treated By Our Office Before: ☐Yes ☐ No	Emergency Contact	Telephone				
Is Your Current Problem Work Related: ☐ Yes ☐ No Accident Case? ☐ Yes☐ No Automobile Related?☐Yes☐No						

Authorization to Release Medical Information

I AUTHORIZE:

TO RELEASE TO:

Name of sending person/organization	Name of receiving person/organization
Street Address	Street Address
City State Zip Code	City State Zip Code

Patients Signature: _____

INFORMATION TO BE RELEASED: (Check All Applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-Ray Reports
☐ Electrocardiograms (EKG) ☐ Allergy Records ☐ Immunization Records ☐ Other: _____

SPECIAL AUTHORIZATION: (Check All Applicable)
By signing below, you are authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Signature: _____

If this release pertains to alcohol, drugs, or mental health information, please note that this is information has been disclosed to you from records protected by Federal Confidentially Rules (42CFR part 2). The Federal Rules prohibit you from making any further disclosures of this unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RECORDS FROM THE PERIOD: ___/___/___ to ___/___/___

PURPOSE OR NEED FOR DISCLOSURE: (Check All Applicable)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal ☐ Personal ☐ Workers' Compensation Claim
☐ Other: _____

I understand that this is authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

I understand that a reasonable charge may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

The requestor may be provided with a copy of this authorization.

Medical History

Patient's Name _____ D.O.B. ___/___/___ Date ___/___/___

Names and Phone Numbers for Health Care Providers from whom you are currently receiving care (or have seen within the past 12 months), or from whom you have received prescriptions.

	Contact #	
	Contact #	
	Contact #	
	Contact #	
	Contact #	
	Contact #	

Please list and describe allergic reactions you have had to food, medications or insect stings.

Check if you are allergic to ○ Shellfish_____ ○IV Contrast Dye _____ ○ Penicillin _____

Medication or Food Allergies	***Describe your Reaction***

History of Falls

In the past 12 months, have you fallen?	○ Yes	○ No
If yes, how many times?		
If yes, have you ever broken bones, or sustained an injury, as a result of falling?	○ Yes	○ No

Vaccination History Have you ever had any of the following vaccinations?

Vaccine		Date of Last Vaccination
Influenza	○ Yes ○ No	
Pneumonia	○ Yes ○ No	
Tetanus	○ Yes ○ No	
BCG	○ Yes ○ No	
HPV (Gardasil)	○ Yes ○ No	

Tobacco Use History		**If yes, please describe**
Have you ever smoked?	○Yes ○ No	

Have you chewed tobacco?	○Yes ○ No	
Have you smoked pipes or cigars?	○Yes ○ No	
Have you quit?	○Yes ○ No	
Have you considered quitting?	○Yes ○ No	
Have you tried quitting?	○Yes ○ No	

Alcohol Use History **If yes, please**

Do you now, or did you once, regularly drink alcohol?	○Yes ○ No	# drinks per **Day**___ **Week**___
1 "drink" is equal to a 12 oz. can of beer, 1.5 oz. liquor, or 5 oz. wine		
Have you ever "blacked out" due to alcohol intake?		○ Yes ○ No
Have you had a drink to prevent the "shakes", "sweats", or developing other problems?		○ Yes ○ No

Recreational Drug Use History

Do you now use, or have ever used, drugs for recreational purposes?	○ Yes ○No
If yes, check all that apply: ○Amphetamines ○ Cocaine	
Have you ever had a problem with addiction to prescription pain medication or benzodiazepines ex; (Valium, Xanax, etc.)	○ Yes ○No

Prior Diagnostic Tests Have you ever had any of the following exams?

Test	Response	Approximate date and reason
Bone Density Test	○ Yes ○No	
Cardiac Stress Test	○ Yes ○No	
Chest X-Ray	○ Yes ○No	
Colonoscopy	○ Yes ○No	
CT "CAT" Scan of Chest	○ Yes ○No	
Echocardiogram	○ Yes ○No	
EEG	○ Yes ○No	
EGD (Esophageal Endoscopy)	○ Yes ○No	
EKG	○ Yes ○No	
Mammogram	○ Yes ○No	
Pap Smear	○ Yes ○No	
Prostate Biopsy	○ Yes ○No	
Pulmonary Function Test	○ Yes ○No	

Female Patients Only

	Response	Descriptions
Have you ever been pregnant?	OYes ONo	
# of Pregnancies		
# of Live Births		
# Miscarriages, Abortions		
Your age at onset of menstruation		
Your age at onset of menopause	ONA	
Have you ever taken birth control pills, or used patches or implants? If yes, how long?	OYes ONo	
Have you ever used hormone replacement therapy? If yes, how long?	OYes ONo	
Did you ever have an IUD (Intrauterine Device) implanted?	OYes ONo	
If you had an IUD, was it removed? If yes, when?	OYes ONo	

Surgical History

Surgery or Procedure	Date of Procedure	Name of Provider Performing Procedure

Past Medical History (Circle yes or no all that apply)

Adrenal Dysfunction	Yes	No	HIV or Aids	Yes	No
Alzheimer's Disease	Yes	No	Hypertension	Yes	No
Amyotrophic Lateral Sclerosis	Yes	No	Hyperthyroidism	Yes	No
Anorexia or Bulimia	Yes	No	Hypotension	Yes	No
Anxiety Disorder	Yes	No	Hypothyroidism	Yes	No
Arteriovenous Malformation	Yes	No	Inflammatory Bowel Disease	Yes	No
Arthritis	Yes	No	Irregular Heart	Yes	No
Autoimmune Disease	Yes	No	Liver Dysfunction	Yes	No
Bipolar Disorder	Yes	No	Kidney Failure or Dysfunction	Yes	No
Bleeding Disorder	Yes	No	Muscular Dystrophy	Yes	No

Cataracts	Yes	No	Myocardial Infarction (Heart Attack)	Yes	No
Chemotherapy	Yes	No	Obstructive Sleep Apnea	Yes	No
Clotting Disorder	Yes	No	Osteoporosis	Yes	No
Congenital Heart Defects	Yes	No	Pancreatitis	Yes	No
Coronary Artery Disease	Yes	No	Personality Disorder	Yes	No
COPD	Yes	No	Radiation Therapy	Yes	No
Cystic Fibrosis	Yes	No	Recurrent Infections	Yes	No
Depression	Yes	No	Restless Leg Syndrome	Yes	No
Diabetes	Yes	No	Schizophrenia	Yes	No
Dialysis	Yes	No	Scoliosis	Yes	No
Eclampsia or Pre-Eclampsia	Yes	No	Seizure Disorder	Yes	No
Endocarditis	Yes	No	Sickle Cell	Yes	No
Endometriosis	Yes	No	Skin Disorders (Psoriasis, Acne)	Yes	No
Erectile Dysfunction	Yes	No	Transfusions	Yes	No
Esophageal Dysfunction	Yes	No	Tuberculosis	Yes	No
Fibromyalgia	Yes	No	Urinary Retention or Urgency	Yes	No
Gall Stones	Yes	No	Vasculitis	Yes	No
Gastritis or Gastric Ulcers	Yes	No			
GERD	Yes	No			
Glaucoma	Yes	No			
Heart or Valve Defects	Yes	No			
Hemmorrhoids	Yes	No			
Hepatitis	Yes	No			

MEDICATION LOG

PATIENT INFORMATION		
Name:	**Date of Birth:**	**Social Security Number:**
Home Address: (Street, City, State & Zip)		**Phone Number:**
Physician: **Phone Number:**	**Pharmacy:** **Pharmacy's Phone Number:**	
Allergies to Medications:		
CURRENT MEDICATION REGIMENT		

MEDICATION	DOSAGE	SPECIAL NOTES

Missed Appointment Notice

If you miss an appointment without a ***24 hr. Notification*** there will be a **$25.00** charge that will be billed to you and will have to be paid before your next office visit. If you miss a diagnostic test appointment without a ***48 hr. Notification*** (ex. Urodynamics, Echo, ABI) there will be **$79.00** charge that will be billed to you and will have to be paid before your next office visit.

**** Effective as of December 1, 2011**

Signature: _____

Print Name: _____

Date: _____