CONFIDENTIAL

PATIENT REGISTRATION

STONE OAK FAMILY PRACTICE AND WOMEN'S HEALTH

Date _____

SS/HIC/Patient ID#_____ Date of Birth _____

Patient Name _____
Last Name First Name Middle Initial

Address _____
Street City State Zip

E-mail_____ Sex ☐ M ☐ F Age_____ Minor ☐

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____ Ext_____

Best Time and Place to Reach You _____

Social Security #_____ Drivers License #_____

Marital Status:

☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Select one of the following Race/Ethnic Groups:

☐ Hispanic ☐ Black ☐ White ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander

Religion (Optional) _____ Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone ( ) _____

Spouse's Information

Spouse's Name _____ Date of Birth _____

Employer _____ Social Security # _____

Minor Information

Guardian/Custodial Parent Name _____

Guardian/Custodial Parent Address _____
Street City State Zip

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____ Ext_____

Employer _____ Social Security # _____

Whom may we thank for referring you?_____

IN CASE OF EMERGENCY, CONTACT

Name _____

Home Phone ( )_____

Cell Phone ( ) _____

Work Phone ( )_____ Ext_____

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MEDICAL HISTORY

Date _____

SS/HIC/Patient ID# _____ Date of Birth _____

Patient Name _____

Patient Concerns: _____

_____ Date of Last Physical Exam _____

STONE OAK
FAMILY PRACTICE
AND WOMEN'S HEALTH

FAMILY MEDICAL HISTORY

	✔ if Alive	Age at Death	Present Health or Cause of Death		# Alive	# Deceased	Present Health or Cause of Death
Father				Brothers			
Mother				Sisters			
Spouse				Children			
				Ages of Living Children:			

CHECK (✔) THE ILLNESSES THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY

☐ DIABETES ☐ CANCER ☐ BLEEDING TENDENCY ☐ KIDNEY DISEASE ☐ TUBERCULOSIS
☐ HEART DISEASE ☐ STROKE ☐ HIGH BLOOD PRESSURE ☐ DEPRESSION ☐ ALLERGIES

MEDICATIONS

LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING.
ALSO LIST ANY VITAMINS, HERBS, SUPPLEMENTS, ETC.

_____
_____
_____
_____

ALLERGIES

CHECK (✔) IF YOUR ARE ALLERGIC TO:

☐ ADHESIVE/TAPE ☐ ASPIRIN
☐ IBUPROFEN ☐ IODINE
☐ LATEX ☐ LOCAL ANESTHESIA
☐ PENICILLIN ☐ SULFA

LIST ALLERGIES TO MEDICATIONS OR SUBSTANCES:

_____
_____

DO YOU TAKE ORAL CONTRACEPTIVES? ☐ YES ☐ NO

PLEASE LIST ANY **CHRONIC CONDITIONS**

_____
_____

ACCIDENTS

_____
_____

PLEASE LIST ANY RECENT **DIAGNOSTIC TESTS**

_____
_____

PLEASE LIST ANY RECENT **INJURIES/ILLNESSES**

_____
_____

HOSPITALIZATIONS

_____
_____

SURGERIES

_____
_____

OTHER HEALTH CARE PROVIDERS

PRIMARY CARE PROVIDER _____

OB/GYN _____

OTHER _____

PREFERRED PHARMACY

_____
Name

_____
Location

_____
Phone Number

DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVES? ☐ YES ☐ NO **MAY WE HAVE A COPY FOR YOUR CHART?** ☐ YES ☐ NO

CERTIFICATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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INSURANCE AND BILLING INFORMATION

STONE OAK
FAMILY PRACTICE
AND WOMEN'S HEALTH

Date _____

SS/HIC/Patient ID#_____ Date of Birth _____

Patient Name _____
Last Name First Name Middle Initial

Who is responsible for this account?_____

Relationship to Patient _____ Date of Birth_____ Social Security #_____

Insurance Company_____

Insurance Company Address_____

Group #/Policy #_____ Identification # _____

Secondary Insurance Information

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____ Date of Birth _____

Social Security #_____ Relationship to Patient _____

Insurance Company_____

Insurance Company Address_____

Group #/Policy #_____ Identification # _____

☐ Insurance Assignment and Release

I certify that I (and/or my dependent(s)) have insurance coverage with

_____ and assign directly to Dr. _____ all insurance
Name of Insurance Company (ies)

benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

☐ Medicare/Medigap Authorization

Medicare No._____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to: _____ for any services furnished to me by that provider. To the extent
Name of Doctor, Clinic, Healthcare Provider or Supplier

permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary