REGISTRATION INFORMATION

(PLEASE PRINT)

Date________________________ Home Phone________________________

Patient____
Last Name / First Name / Initial

Responsible Party (if a minor)____

Street Address____

City______________________________ State________________ Zip____________

Sex ☐ M ☐ F Age_____ Birthdate__________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Full-Time Student ☐ Part-Time Student Patient's School Name________________________

Patient Employed By____

Business Address____

Occupation______________________________ Business Phone________________________

Spouse (or responsible party) Name______________________________ Birthdate________________

Business Name and Address____

Occupation______________________________ Business Phone________________________

Who is responsible for this account?______________________ Relationship to Patient________________

Social Security #______________________ Spouse's Social Security #______________________

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Primary Insurer____

Contract #______________ Group #______________________ Subscriber #______________________

Name of Secondary Insurer (if any)____________________________________

Contract #______________ Group #______________________ Subscriber #______________________

Are you covered under any of these programs? ☐ Medicare ☐ Medicaid ☐ CHAMPUS ☐ CHAMPVA

☐ Worker Compensation ☐ FECA Black Lung I.D. # for program you've checked________________________

If Welfare, your number______________________________ County of________________________

Is your condition related to employment (current or previous) ☐ No ☐ Yes

Is your condition related to auto accident? ☐ No ☐ Yes In which state?________________________

Other Accident? ☐ No ☐ Yes Please describe____

In case of emergency, who should be notified?____

Phone______________________ Relationship to patient______________________________

(OVER)

Please list other doctors you have seen in the past 5 years:

1.______________________________ City/State______________
(General Practitioner, Specialist, or other)

Reason for seeing______________________________

2.______________________________ City/State______________
(General Practitioner, Specialist, or other)

Reason for seeing______________________________

How did you learn of our practice?______________________________

Whom may we thank for referring you?______________________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ______________________________
Name of Insurance Company

and assign directly to Dr.______________________________ all medical 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

______________________________ ______________
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr.______________________________ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________
Beneficiary Signature Date

OFFICE NOTES

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Patient History Form

Name: ______________________________
Address: ______________________________
City: ______________ State___ Zip________
Alternate
Address: ______________________________
City: ______________ State___ Zip________
Phone: ______________________________
Alternate Phone: ______________________
Education: (brief description)

Age:_____ Birthdate__________
Birthplace______________________
Religion:______________________
Marital Status:__________________
Occupation:____________________
List all States and Countries in which you have lived:______________________
____

HPI: (to be filled in by the physician)

Past Medical History: List all illnesses for which you have been treated in the past. (Include those requiring hospitalization.)

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

Past Surgical History: List all surgeries (include dates and place of operation)

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

Family History

Relation	Age	Living?	(Y/N)
Father			
Mother			
B / S			
B / S			
B / S			
B / S			
Spouse			
Children			

Has any blood relative

ever had:	YES or NO	Relation
Cancer	YES or NO	
Diabetes	YES or NO	
Heart Disease	YES or NO	
High Blood Pressure	YES or NO	
Stroke	YES or NO	
Thyroid Problems	YES or NO	
Epilepsy	YES or NO	
Tuberculosis	YES or NO	
Mental Illness	YES or NO	
Kidney Problems	YES or NO	
Suicide	YES or NO	

Habits: Do you...
sleep well? YES or NO
use alcoholic beverages? YES or NO
How much? ____________
use tobacco? YES or NO
How much? ____________
How long? ____________
exercise? (describe) ____________
____

*** WOMEN ONLY:**
Menstruation history:
Age of onset? ____________
Cycles: (circle one)
REGULAR OR IRREGULAR
Duration: ____ days
Flow: (circle one)
HEAVY / MEDIUM / LIGHT
Pain or Cramps? YES or NO
Contraceptives? YES or NO

Last Menstrual Period ____________
Number of Pregnancies ____________
Full Term ____________
Premature ____________
Abortions ____________
Miscarriages ____________
Living ____________
Complications ____________
____

List **ALL** medications with dosage schedules:

1. ____________ 6. ____________
2. ____________ 7. ____________
3. ____________ 8. ____________
4. ____________ 9. ____________
5. ____________ 10. ____________

MEDICATION ALLERGIES:

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________

Review of Systems: (Circle any symptoms you may have now. If any were present in the past, explain on the next page. Fill in answers when appropriate.)

General:	Weight_____lbs. Weight at age 18_____lbs. Recent change of weight?___how much?______lbs. Appetite _________, weakness, fatigue, fever, chills, night sweats, anorexia, syncope, insomnia, sleeping habits_______________.
Skin:	color change, itching, rash, moles, change in moles, infections, cancer.
Head:	Headaches, trauma.
Eyes:	vision, glasses, blindness or blind spots, pain, tearing, redness, itching, burning dryness, glaucoma.
Ears:	hearing loss, deafness, discharge, pain, vertigo, tinnitus.
Nose and sinuses:	decreased sense of smell, bleeding, dryness, discharge, obstruction, pain, sinusitis, hay fever.
Mouth:	cavities, painful teeth, bleeding gums, sore tongue, postnasal drip, oral ulcers, thrush, lip lesion, fever blisters, canker sores.
Throat:	Sore throat, hoarseness, painful swallowing, tonsillitis.
Neck:	Stiffness, decreased motion, pain, lumps in neck, swollen glands, goiter.
Breasts:	lumps, discharge, pain, bleeding, nipple inversion, change in size, tenderness.
Respiratory:	cough, sputum, color?____ pleurisy, coughing up blood, wheezing, shortness of breath, recurrent respiratory infection, exposure to tuberculosis, positive TB skin test.
Cardiac:	chest pain, shortness of breath on exertion, palpitations, swelling, ever pass out?____, rheumatic fever, abnormal EKG?____, if so, when?_____.
Vascular:	high blood pressure, phlebitis, varicose veins, blood clots, leg cramps with walking, Raynaud's phenomenon.
GI:	nausea, vomiting, vomiting up blood, heartburn, problems swallowing, jaundice, clay-colored stools, dark urine, recent change in bowel habits, blood in stools, black tarry stools, hemorrhoids, rectal abcess or fissure, hernia.
GU:	painful urination, poor urinary stream, frequent awakenings to urinate, incontinence, kidney stones, frequent urine infections (cystitis, prostatitis), venereal disease, vaginal/pelvic infections, impotence.
MS:	muscle pain, cramps, weakness, joint pain, stiffness or deformity, broken bones.
Endocrine:	heat or cold intolerance, frequent drinking, frequent urination, goiter.
CNS:	seizures, strokes, tremor, incoordination, fainting, numbness, tingling, memory loss, depression, anxiety, nervous breakdown.