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Please Print

Patient Registration Form

Date:___/___/___

Last Name:_____ First Name:_____ MI:_____

Address:_____ Phone: _____ Primary Care Physician:_____
(street name & number)

_____ Work Phone: ( )_____ Ext:_____ Gender: M F
(city)

_____ Social Security#:_____ Referred by: _____
(state/zip)

Employer:_____ DOB:___/___/___ Marital Status: S M D W

Occupation:_____ Pharmacy: _____

INSURANCE INFORMATION

Primary Insurance:_____ Secondary Insurance:_____

ID#: _____ ID#: _____

Group#:_____ Group#:_____

Name of Insured:_____ Name of Insured:_____

Insured Date of Birth:___/___/___ Insured Date of Birth:___/___/___

Insured Social Security#:_____ Insured Social Security#:_____

EMERGENCY CONTACT:

Name	Phone Number	Address	
Relationship to Patient	City	State	Zip

GUARANTOR (PERSON RESPONSIBLE FOR BILL) INFORMATION:

Last Name:_____ First Name:_____ MI:_____

Relationship to patient:_____

I understand that I am responsible for all financial obligations of health services and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all billing charges, interest charges, collection costs and reasonable legal fees.

_____ Date:___/___/___
Patient or Guardian

Name:_____ Age:_____ Date:___/___/___ DOB:___/___/___

MEDICAL HISTORY

Allergies to medication? ( ) Yes ( ) No If "YES", list medications:_____

_____

Allergies to: IODINE_____ SULFA _____ SHELLFISH_____

Do you currently have problems in any of the following areas?

	YES	NO
Anemia (low, weak blood)	____	____
Arthritis / Rheumatism	____	____
Asthma	____	____
Bleeding Tendency / Unusual Bruising	____	____
Bowel Disorders / Colitis / Crohns	____	____
Cancer / Tumors	____	____
Diabetes	____	____
Gallbladder Trouble / Gallstones	____	____
High Blood Pressure / Hypertension	____	____
Heart Disease	____	____
Hepatitis	____	____
Skin (warts, skin cancer, unusual moles)	____	____
Neurological Problems	____	____
Respiratory (Recurrent pneumonia, bronchitis, emphysema)	____	____

If "YES" to any of the above, please provide details here:_____

_____

_____

_____

FAMILY HISTORY: (If "YES", indicate relationship to pt.): M=mother, F=father, S=sibling, GP=grandparent

DISEASE	YES	NO	REL.	DISEASE	YES	NO	REL.
High Blood Pressure	( )	( )	____	Anemia	( )	( )	____
Heart Disease	( )	( )	____	Bleeding Disorder	( )	( )	____
Cancer	( )	( )	____	Diabetes	( )	( )	____
Gastrointestinal Problems	( )	( )	____				

SOCIAL HISTORY:

Do you drink alcohol?	( )	( )	( ) occasional ( ) 1/day ( ) 2-3/day ( ) 4+/day
Do you smoke?	( )	( )	( ) 1/2 pack or less/day ( ) 1 pack/day ( ) 1+ pack/day
Any cultural / language barriers?	( )	( )	
Advanced directives?	( )	( )	

Physician's signature:_____ Date:___/___/___