

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)	Social Security Number		
Patient's Address		City	State	Zip	
Home Phone		Mobile Phone	Email Address		
Referred by		Primary Care Physician	Primary Care Physician Phone		
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone			
Employer/School Address		City	State	Zip	

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient
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Billing and Insurance

Primary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School			
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number		
Insured's Address		City	State	Zip	
Insured's Social Security Number	Insured's Birthdate				

Secondary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number		
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number		

Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient		
Address		City	State	Zip	

Signature of Patient or Authorized Guardian

Date

Name _____

Gender _____

Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

Excellent Good Fair Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Are you allergic to any of the following?

Adhesive Tape Antibiotics Latex
 Barbiturates (Sleeping Pills) Aspirin Iodine
 Codeine Sulfa Local Anesthetics

Do you have any other allergies?

Name	Reaction
_____	_____
_____	_____

Past Medical History

- | | | | | | |
|---|--|--|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Hepatitis - A, B, or C | <input type="checkbox"/> Measles | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Joint Disorder | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke | |

Hospitalizations & Surgeries

Reason	Date
_____	_____
_____	_____

Women Only:

# of Pregnancies _____	# of Miscarriages _____	# of Abortions _____	# of Living _____
Last Pap Smear _____	Last Mammogram _____	Birth Control Method _____	

Family History

Has anyone in your family ever had any of the following conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder |

Details: _____

Lifestyle Factors

Are you sexually active?

Yes No # of partners in past year _____

Do you wish to be checked for STDs?

Yes No

Has anyone in your home ever physically or verbally hurt you?

Yes No

Have you ever smoked?

Yes No # of years _____ # packs/day _____

Do you smoke now?

Yes No # packs/day _____

Do you use recreational drugs?

Yes No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Name _____

Gender _____

Age _____

Date of Appointment: _____

Review of Systems

General

- Chills
- Dizziness
- Fainting
- Fever
- Hair Loss
- Hair Growth - Excessive
- Night Sweats
- Sleeping Problems
- Thirst - Excessive
- Weight Gain
- Weight Loss

Mental Health

- Anxiety
- Depression
- Loss of Interest
- Feeling Hopeless
- Hearing Voices
- Marital Problems
- Panic Attacks
- Trouble Concentrating
- Suicide - Thoughts/Attempts

Skin

- Acne
- Bruise Easily
- Changes in Moles
- Chills
- Dry / Sensitive Skin
- Eczema
- Hives
- Itching
- Rash
- Scars
- Sores That Won't Heal

Gastrointestinal

- Appetite Gain
- Appetite Loss
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Indigestion
- Intestinal Disorder
- Lactose Intolerance
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

Genitourinary

- Blood in Urine
- Lack of Bladder Control
- Frequent Urination
- Painful Urination

Neurological

- Coordination Problems
- Convulsions
- Difficulty Walking
- Learning Disabilities
- Light-headedness
- Memory Loss
- Numbness / Tingling
- Paralysis
- Seizures
- Speech Problems
- Tremors

ENT

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earaches
- Ear Discharge
- Hay Fever
- Hoarseness
- Hearing Loss
- Nose-Bleeds
- Persistent Cough
- Persistent Runny Nose
- Recurring Sore Throat
- Ringing in Ears
- Sinus Problems
- Vision Halos

Respiratory

- Coughing
- Coughing Up Blood
- Shortness of Breath
- Wheezing

Cardiovascular

- Chest Pains
- Irregular Heart Beat
- Circulation Problems
- Heart Palpitations
- Rapid Heartbeat
- Swelling of Ankles
- Varicose Veins

Musculoskeletal

- Back Pain
- Carpal Tunnel Syndrome
- Joint Pain
- Joint Swelling
- Neck Pain
- Shoulder Pain

Men Only

- Erection Difficulties
- Lump in Testicles
- Penile Discharge
- Sore on Penis

Women Only

- Abnormal Pap Smear
- Bleeding between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge

Other Symptoms

Health Exams & Procedures

Please check and date the last time you had each exam or procedure performed.

<input type="checkbox"/> Cholesterol Test	Month & Year _____	<input type="checkbox"/> MRI	Month & Year _____
<input type="checkbox"/> Colonoscopy	Month & Year _____	<input type="checkbox"/> Physical Exam	Month & Year _____
<input type="checkbox"/> CT/CAT Scan	Month & Year _____	<input type="checkbox"/> Cardiac Stress Test	Month & Year _____
<input type="checkbox"/> EKG	Month & Year _____	<input type="checkbox"/> Ultra Sound	Month & Year _____
<input type="checkbox"/> Echocardiogram	Month & Year _____		

Immunizations

Please check and date all immunizations you have had.

<input type="checkbox"/> Hepatitis A	Month & Year _____	<input type="checkbox"/> MMR (Measles, Mumps, Rubella)	Month & Year _____
<input type="checkbox"/> Hepatitis B (Series of 3)	Month & Year _____	<input type="checkbox"/> Pneumonia	Month & Year _____
<input type="checkbox"/> HPV Vaccine	Month & Year _____	<input type="checkbox"/> Polio	Month & Year _____
<input type="checkbox"/> Influenza (Flu Shot)	Month & Year _____	<input type="checkbox"/> Tetanus	Month & Year _____
<input type="checkbox"/> Meningitis	Month & Year _____		