

# 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 Lives with:	Date of Birth (Age) / / ( ) 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 - Claims 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?

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Adhesive Tape                 | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Latex             |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Iodine            |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa       | <input type="checkbox"/> 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/Seizure | <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/STDs |
| <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 (Include ONLY - Birth Parents & Grandparents)**

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? Use Condoms Regularly?

Yes  No 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 \_\_\_\_\_