Revised 6/4/14

For Office Use Only
Dr #______________

PLEASE PRINT

PATIENT REGISTRATION FORM

Patient Name : ____
(Last) (First) (MI)

Sex ☐M ☐F

Email Address: ________________________

Date of Birth : ________________________ SS# ____________________________________ Age : ______

Marital Status : ☐Single ☐Married ☐Divorced ☐ Separated

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refuse

Race: ☐ American Indian ☐ Asian/ Alaskan ☐ Black/African American ☐ Pacific Islander ☐Caucasian/White ☐ Refuse

Preferred Pharmacy: ________________________ ________________________

Patient Address: ____
Street, Apt.# (City, State) (Zip)

Patient Phone No. (Incl. Area Code): (H) ______________ (W) ____________ (cell) ____________________

Responsible Party (If Other than Patient) : ____

Responsible Party Address (If Different from Patient) : ____

Responsible Party Phone No. (If Different from Patient) : (H) ________________ (W) ________________________

Responsible Party Employer : ____

Emergency Contact: ____

INSURANCE INFORMATION

Primary Insurance

Name of Insurance Co: ____

Name of Subscriber: ______________________________ Subscriber's Date of Birth: ________________________

Subscriber's SS# _________________ Sex ______ Employer of Subscriber : ______________________________

Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Policy Effective Date: ______________ Policy# ________________________ Group # ________________________

Secondary Insurance

Name of Insurance Co: ____

Name of Subscriber: ______________________________ Subscriber's Date of Birth: ________________________

Subscriber's SS# _________________ Sex ______ Employer of Subscriber : ______________________________

Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Policy Effective Date: ______________ Policy# ________________________ Group # ________________________

Statement of Responsibility

The coverage your insurance program provides is calculated based on their allowed amount, minus deductibles, copayments and/or coinsurance amounts. These amounts are your share of the cost.

The amount your insurance will pay is determined by them and is the amount they determine to be appropriate for the service rendered. They have the sole discretion to determine the allowed amount. Your insurance company has also the discretion to determine whether care is medically necessary. They will not cover care they feel is not medically necessary.

Precertification or certification is obtained from your insurance company. If you do not obtain certification when required, your benefits will be reduced or denied. Your insurance certification of your care does not guarantee coverage.

Therefore; it is your responsibility to cover any and all charges not paid by your insurance company. This will include the fees we charge for cancellation of appointments without a twenty-four hour notice. If it is a true emergency the charges for cancellation will up to the physician's discretion and determination.

Medical Specialists will expect all payment of charges on the day service is rendered. Please come prepared to pay deductible amounts not yet satisfied, charges not covered by your insurance, and co-payments.

RESPONSIBLE PARTY SIGNATURE:

____________________________________ __________

Name Date

Personal Medical History

Name: ________________________________ Age: __________ Date: ___________________

Please list any medications you are currently taking including over the counter medicines, vitamins or "home" remedies.

Regularly	**Occasionally**
1______________________________________	1____________________________________
2______________________________________	2____________________________________
3______________________________________	3____________________________________
4______________________________________	4____________________________________
5______________________________________	5____________________________________

Please list any medications to which you have had allergic reactions or cannot take:

Please list any childhood illness/immunizations and the approximate date of the illness or immunization:

Name: ______________________________

Have you ever had any of the following? If so when?

☐Glaucoma ________
☐Ulcers __________
☐X-ray or radiation treatments _______
☐Black bowels________
☐Meningitis_________
☐Alcohol Dependency _______
☐Liver Disorder _________
☐Phlebitis ___________
☐Gallbladder X-ray _______
☐Excessive bleeding _________
☐Heart Condition __________
☐Blood in bowels ___________
☐Stroke __________
☐Heart Attack _________
☐Yellow Jaundice
☐V.D. _________
☐Goiter _________
☐Blood sugar too high _________
☐Colitis __________
☐Convulsions __________
☐Thyroid Disorders _________
☐High Blood Pressure _________
☐Bladder Infection __________
☐Kidney Condition _________
☐Drug Dependency _________
☐Hepatitis _________
☐Blood clot ________
☐Diabetes ________
☐Anemia ________
☐T.B. ________
☐Vomit Blood ________
☐Paralysis __________
☐Angina Pectoris _________
☐Arthritis __________
☐Mental Illness ___________
☐Asthma ___________
☐Stomach X-ray __________
☐Heart Murmur _________
☐Rheumatic Fever _________
☐Gout _________
☐Prostate Trouble _______
☐Gallbladder Disorder _________

Other Medical Illness: ____

List any hospitalizations for illness or tests not requiring surgery (include psychiatric):

List any surgeries you have had and the appropriate date(s)

Name: ______________________________

Family History

Please Check

	Father	**Mother**	**Grandparents**	**Siblings**	**Children**
Alive Or Deceased	□Alive □Deceased	□Alive □Deceased	□Alive □Deceased	□Alive □Deceased	□Alive □Deceased
Ulcer Disease					
Liver Disease					
Diabetes					
Heart Attack					
Stroke					
Cancer(specify)					
Hypertension					
High Cholesterol					
Blood Disorders					
Osteoporosis					
Depression					
Alcoholism					
Other Please specify					

Name: ______________________________

How many of the following do you consume daily?

_____Cigarette _____Beer _____Coffee ______Cigars ______Wine
_____Tea _____Pipe _____Hard Liquor ______Soft Drinks

Have you ever experienced the following in the past ONE MONTH? (check)

☐**Hearing loss**
☐**Ringing in ears**
☐**Dizziness**
☐**Failing vision**
☐**Eye pain**
☐**Hoarseness**
☐**Chest pain**
☐**Shortness of Breath**
☐**Cough all day**
☐**Vomiting**
☐**Abdominal pain**
☐**Persistent loss of appetite**
☐**Constipation**
☐**Weakness**
☐**Skin Rash**
☐**Painful voiding**
☐**Bloody Urine**
☐ **Tiredness**
☐ **Fainting**
☐ **Headaches**
☐ **Trouble Sleeping**
☐ **Painful Swallowing**
☐ **Nervousness or Depression**
☐ **Pain in legs or arms**
☐ **Joint discomfort or stiffness**
☐ **Diarrhea**

In the PAST YEAR had there been a change in weight?

When was the last time you had a Chest X-Ray? EKG?

If Applicable:

☐**When was your last period? __________________**
☐**Any spotting?__________________________**
☐**When was your last Pap Smear? ____________________**
☐**Number of Pregnancies? _______________________**
☐**Number of Miscarriages? ___________________**