Patient Registration Form

Patient Information

Name (First, MI, Last) _____ Set _____ Home Phone _____

Address (Street) _____ Social Security Number _____

City, State, Zip _____ DOB _____ Marital Status _____

Employer _____ Job Title _____ Work Phone _____ Cell Phone _____

Name and phone number of emergency contact _____ Relation to patient _____

Pharmacy _____ Location _____ Phone _____

Referring Physician Information

Referred by _____ Office Phone _____

Address _____

Primary Care or Family Physician _____ Office Phone _____

Address _____

Would you like us to send a copy of your visit to your referring/family doctor? (circle) Yes No

Insurance Information

Primary Insurance Carrier _____ ID Number _____

Policy Holder's Name (First, MI, Last) **If different than patient** _____ Group Number _____

Phone (Of Policy Holder) _____ Relationship _____ DOB (Of Policy Holder) _____ Sex (Of Policy Holder) _____

Social Security Number (Of Policy Holder) _____ Effective Date of Insurance _____

Secondary Insurance Carrier _____

Policy Holder's Name (First, MI, Last) _____ Relationship to Patient _____

Patient Name:_____ **Date of Birth**:_____

Primary Care Physician

Name: _____

Address:_____

_____

_____

Phone Number: _____

Referring Physician (who sent you to us)

❒ Same as Primary Care Physician

Name: _____

Address: _____

_____

Phone Number: _____

Medical History: Please place a mark in the box if you have, or have ever had, one of the following conditions:

Bleeding Problems		High Cholesterol		Blood Clot	
Irregular Heart Beat		Diabetes		Gallbladder Problems	
High Blood Pressure		Sleep Apnea		Arthritis/Back Pain/Joint Pain	
Reflux Disease (Heartburn)		Thyroid Disease		Other Conditions (List Below):	
Irritable Bowel Syndrome		Seizures			
Inflammatory Bowel Disease		Stroke			
Asthma/Emphysema/COPD (Circle Which)		Stomach Ulcer			
Hepatitis/HIV/AIDS (Circle Which)		Diverticulitis			
Cancer (Type:_____)		Kidney Stones			
Heart Attack (When:_____)		Fibromyalgia			
Reaction to Anesthesia (Reaction:_____)		Autoimmune Disease			

Surgical History: Please list any past procedures and the approximate date they occurred.

Social History:

Do you smoke? _____ If yes, how many packs a day? _____ If no, when did you quit? _____

Do you drink? _____ If yes, how many per week? _____ If no, when did you quit? _____

Do you use any other drugs (marijuana, cocaine, chewing tobacco, etc)? _____

If yes, what? _____ If no, quit when? _____

If you are a woman, are you pregnant? _____

Occupation: _____

Are you married? _____ Do you have any children? _____ Do you live alone? _____

Family History: Do any of the following conditions run in your family?

Condition	Yes	Relative	Condition	Yes	Relative
Diabetes			Seizures		
Heart Disease			High Blood Pressure		
Inflammatory Bowel Disease			Stroke		
Cancer			If yes, what kind of cancer?		

Allergies: Please list any medication allergies and the associated reactions.

Medications: Please list your current medications, including any herbal supplements or over the counter drugs.

Medication Name	Strength	Dose	Frequency

Review Of Systems: Please place a mark in the box if you CURRENTLY have any of the following symptoms.

Recent Weight Loss		Muscle Pain or Cramps		Blood in Stool	
Night Sweats		Back or Joint Pain		Bruise Easily	
Fatigue		Pain with Urination		Slow to Heal	
Fevers		Difficulty Urinating		Sore Throat	
Chest Pain		Blood in Urine		Rash	
Palpitations		Shortness of Breath		Keloids (Abnormal Scarring)	
Heart Trouble		Nausea or Vomiting		Blurred Vision	
Swelling of Hands/Feet		Diarrhea or Constipation		Headaches	
List any other significant symptoms:					