NEW PATIENT REGISTRATION

PATIENT

Name _____ _____ _____ _____ _____ _____ _____
Title First Middle Last Suffix Degree Nickname

Sex _____ Age _____ Birth Date _____ SS# _____ PTUID# _____

Marital Status Married Single Widow(er) Divorced Separated Unknown

Address _____ _____ _____ _____ _____
Line #1 Line #2 City State Zip

Phone Numbers _____ _____ _____ _____
Home Cell Work Ext

_____ _____ _____
Other FAX Pager

E-Mail _____ _____
Personal Work

Occupation _____ _____
Description Occupation Code

Driver's License _____ _____ _____
Number State Expiration Date

Employer _____ Employment Status Full time Part time Not employed
Self Employed Retired Active Duty Unknown

Employer Address _____ _____ _____ _____
Line #1 City State Zip

_____
Line #2

_____
Signature

REGISTRATION CONTINUED _____ Name _____ DOB _____ Date

EMERGENCY CONTACT #1

Name _____ Title _____ First _____ Middle _____ Last _____ Suffix _____ Degree _____ Relation

Sex _____ Age _____ Birth Date _____

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

Phone Numbers _____ Home _____ Cell _____ Work _____ Ext

_____ Other _____ FAX _____ Pager _____ PIN

E-Mail _____ Personal _____ Work

Occupation _____ Description _____ Occupation Code

Driver's License _____ Number _____ State _____ Expiration Date

PTUID#_____

Employer _____ Employment Status Full time Part time Not employed Self Employed Retired Active Duty Unknown

Employer Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

REGISTRATION CONTINUED _____ Name _____ DOB _____ Date

INSURANCE #1 Insured ID#

Company _____ Name _____ Website

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

Phone Numbers _____ Company _____ FAX _____ Eligibility _____ Authorizations

INSURANCE #2 Insured ID#

Company _____ Name _____ Website

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

Phone Numbers _____ Company _____ FAX _____ Eligibility _____ Authorizations

INSURANCE #3 Insured ID#

Company _____ Name _____ Website

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

Phone Numbers _____ Company _____ FAX _____ Eligibility _____ Authorizations

REGISTRATION CONTINUED _____ Name _____ DOB _____ Date

REFERRING PROVIDER

Name _____ Title _____ First _____ Middle _____ Last _____ Suffix _____ Degree _____ Phone #

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

ATTENDING DOCTOR

Name _____ Title _____ First _____ Middle _____ Last _____ Suffix _____ Degree _____ Phone #

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

PRIMARY CARE PHYSICIAN

Name _____ Title _____ First _____ Middle _____ Last _____ Suffix _____ Degree _____ Phone #

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

PRIMARY PHARMACY

Pharmacy

_____ Name _____ Phone # _____ FAX

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

REGISTRATION CONTINUED _____ _____ _____

Name DOB Date

CURRENT MEDICATIONS

	Date	Medication Name and Dose	SIG	Prescribed by Dr
1.				
2.				
3.				
4.				
5.				
6.				

Allergy	Reaction

Please list present and past medical illnesses or problems.

Date	Problem or Diagnosis	Diagnosis Code (if known) ICD10	Snomed CT
		ICD10	Snomed CT
		ICD10	Snomed CT
		ICD10	Snomed CT

Have you EVER had, or have you ever been diagnosed with any of the following?

Alcoholism
Allergic disorders
Allergy to latex
Allergy injection therapy
Anemia
Anorexia nervosa
Anxiety disorder
Arteriosclerosis
Arthritis
Asthma
Attention deficit disorder
Back pain, chronic
Bladder infection
Bleeding disorder
Blood clots, deep vein
Blood disorders
Broken bones
Bulimia
Cancer - Breast
Cancer - Colon
Cancer - Lung
Cancer – Lymphatic / lymphoma
Cancer - Other
Cancer - Pancreas
Cancer - Prostate
Cancer - Thyroid
Cancer - Unspecified
Chicken pox
Chronic cough
Chronic fatigue syndrome
Chronic lung disease
Concussion
Congestive heart failure
Depression
Diabetes - Type 1
Diabetes - Type 2
Diabetes - Type unknown
Drug problem
Eating disorder
Emphysema
Endometriosis
Epilepsy
Eye problems, serious
Food allergy, serious
Gallstones
Gout
Hay fever / allergic rhinitis
Head injury, serious
Headaches, severe, non-migraine
Hearing loss
Heart Attack
Heart Disease
Heart murmur
Hepatitis B
Hepatitis C
Hernia
High Blood Pressure
High Cholesterol
HIV infection
Hypertension
Inflammatory bowel disease
Irregular periods
Jaundice
Knee problems
Kidney disease
Learning disability
Loss of consciousness
LD / ADD / ADHD
Malaria
Mammogram, abnormal
Menstrual problems
Migraine
Mononucleosis
Neck injury
Obsessive / compulsive
Overweight / Obesity
Pap smear, abnormal
Parasitic disease
Pelvic inflammatory disease
Pilonidal cyst
Prostatitis
Pneumonia
Repetitive stress injury
Rheumatic fever
Seizure
Shortness of breath
Sickle Cell Anemia
Sinusitis
Skin problems
Sleep disorder / insomnia
Smoker, current
Smoker, past
Stroke
Thyroid disorder
Tuberculosis
Ulcer, stomach or peptic
Urinary tract infection, recurrent
Weight gain or loss, recent
Heart / vascular problems
Aneurysm
Angina
Congestive heart failure
Heart attack (myocardial infraction)
Stroke
Sexually transmitted disease
Chlamydia
Genital warts / HPV
Gonorrhea
Herpes, genital
Syphilis
Other