NEW PATIENT REGISTRATION

PATIENT

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

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

Address _____ (Line #1) _____ (City) _____ (State) _____ (Zip)

_____ (Line #2)

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)

Marital Status | Married Single Widow(er) Divorced Separated Unknown

REGISTRATION CONTINUED _____ _____ _____
Name DOB Date

SPOUSE/SIGNIFICANT OTHER

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

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

Address _____ _____ _____ _____
same 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

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

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

EMERGENCY CONTACT #2

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

RESPONSIBLE PERSON

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 _____

NEXT OF KIN

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

Company _____ Name _____ Website

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

Phone Numbers _____ Company _____ FAX _____ Eligibility _____ Authorizations

INSURANCE #2

Company _____ Name _____ Website

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

Phone Numbers _____ Company _____ FAX _____ Eligibility _____ Authorizations

INSURANCE #3

Company _____ Name _____ Website

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

Phone Numbers _____ Company _____ FAX _____ Eligibility _____ Authorizations

REGISTRATION CONTINUED _____ Name _____ DOB _____ Date

SUBSCRIBER #1

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

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

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

_____ Insured ID# _____ Group# _____ Plan Name _____ Prefix _____ Local _____ Pt Co-pay _____ %Pt Pays _____ Max Deductible

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

Marital Status Married Single Widow(er) Divorced Legally Separated Unknown

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

SUBSCRIBER #2

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

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

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

_____ Insured ID# _____ Group# _____ Plan Name _____ Prefix _____ Local _____ Pt Co-pay _____ %Pt Pays _____ Max Deductible

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

Marital Status Married Single Widow(er) Divorced Legally Separated Unknown

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

SUBSCRIBER #3

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

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

Address _____ _____ _____ _____
Line #1 City State Zip

_____
Line #2

_____ _____ _____ _____ _____ _____ _____ _____
Insured ID# Group# Plan Name Prefix Local Pt Co-pay %Pt Pays Max Deductible

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

Marital Status Married Single Widow(er) Divorced Legally Separated Unknown

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

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

DENTIST

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

Address _____ Line #1 _____ City _____ State _____ Zip

_____ Line #2

REGISTRATION CONTINUED _____ _____ _____
Name DOB Date

PHARMACY PREFERENCE

Pharmacy _____ _____ _____
Name Phone # FAX

Address _____ _____ _____ _____
Line #1 City State Zip

_____
Line #2

PRIMARY HOSPITAL – PREFERRED

Hospital _____ _____ _____
Name Phone # FAX

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

_____
Line #2

SECOND CHOICE HOSPITAL

Hospital _____ _____ _____
Name Phone # FAX

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

_____
Line #2

THIRD CHOICE HOSPITAL

Hospital _____ _____ _____
Name Phone # FAX

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

_____
Line #2

REGISTRATION CONTINUED _____ _____ _____
Name DOB Date

ATTORNEY

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

Corporation _____
Name

Address _____ _____ _____ _____
Line #1 City State Zip

_____
Line #2

Phone Numbers _____ _____ _____ _____
Home Cell Work Ext

_____ _____ _____ _____
Other FAX Pager PIN

E-Mail _____ _____
Personal Work

REGISTRATION CONTINUED _____ _____ _____

Name DOB Date

CURRENT MEDICATIONS

	Date	Medication Name and Dose	SIG	Prescribed by Dr
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

This medication list is not complete. It continues on a separate form

 Name _____ DOB _____ Date _____

ALLERGIES DIAGNOSED BY YOUR DOCTOR

Allergy	Reaction

PATIENT REPORTED ALLERGIES

Allergies to Medications

None
Anticonvulsants
Barbiturates
Insulin preparations
Iodine
Local anesthetics
Penicillin
Sulfa drugs

Allergies to Food

None
Beets
Chocolate
Dairy
Eggs
Grains
Milk
Nuts
Peanuts
Strawberries
Shellfish

Allergies – Environmental

None
Fiber
Grass
Household cleaners
Mold
Nickel or other metals
Pets
Pollen
Trees
Wool

Allergies – Bites / Stings

None
Honeybees
Yellow jackets
Hornets
Wasps
Scorpions
Spiders

Other Known Allergies

_____
_____
_____
_____

PROBLEMS

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

HOSPITALIZATIONS

Please list all past surgeries and hospitalizations and the approximate dates.

Procedures / Hospitalizations	Date Range		Complications

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

Name _____ DOB _____ Date _____

Personal Habits

Caffeine: None

Caffeine: 1 caffeinated drink per day

Caffeine: 1 - 2 caffeinated drinks per day

Caffeine: 3 - 5 caffeinated drinks per day

Caffeine: 6 - 8 caffeinated drinks per day

Caffeine: more than 8 drinks per day

Started using caffeine: 10 - 15 years old

Started using caffeine: 16 - 18 years old

Started using caffeine: 19 - 21 years old

Started using caffeine: 22 - 25 years old

Started using caffeine: 26 - 30 years old

Started using caffeine: over 30 years old

Caffeine habit: Occasional

Caffeine habit: Regular

Caffeine habit: Heavy

Caffeine habit: Stress related

Alcohol: None

Alcohol: 1 drink per day

Alcohol: 2 drinks per day

Alcohol: 3 drinks per day

Alcohol: 4 or more drinks per day

Started drinking: 10 - 15 years old

Started drinking: 16 - 18 years old

Started drinking: 19 - 21 years old

Started drinking: 22 - 25 years old

Started drinking: 26 - 30 years old

Started drinking: over 30 years old

Alcohol habit: Occasional

Alcohol habit: Regular

Alcohol habit: Heavy

Alcohol habit: Alcoholic

Alcohol habit: Stress related

Cigarettes: None

Cigarettes: 1 - 2 per day

Cigarettes: 3 - 5 per day

Cigarettes: 5 - 10 per day

Cigarettes: 1 pack per day

Cigarettes: 2 or more packs per day

Started smoking: 10 - 15 years old

Started smoking: 16 - 18 years old

Started smoking: 19 - 21 years old

Started smoking: 22 - 25 years old

Started smoking: 26 - 30 years old

Started smoking: over 30 years old

Smoking habit: Occasional

Smoking habit: Regular

Smoking habit: Heavy

Smoking habit: Stress related

Hard Drugs: None

Hard Drugs: once per day

Hard Drugs: twice per day

Hard Drugs: three times per day

Hard Drugs: three or more times per day

Started hard drugs: 10 - 15 years old

Started hard drugs: 16 - 20 years old

Started hard drugs: 21 - 25 years old

Started hard drugs: 26 - 30 years old

Started hard drugs: 31 - 35 years old

Started hard drugs: 36 - 40 years old

Started hard drugs: over 40 years old

Hard Drug habit: Occasional

Hard Drug habit: Regular

Hard Drug habit: Heavy

Hard Drug habit: Stress related

Other Drug habit: None

Other Drug habit: Occasional

Other Drug habit: Regular

Other Drug habit: Heavy

Other Drug habit: Stress related

Personal Habits – Exercise

Exercise – never

Exercise – occasional

Exercise - once / week (30 mins or less)

Exercise - once / week (30 - 60 mins)

Exercise - once / week (60 - 90 mins)

Exercise - once / week (90 mins or more)

Exercise - twice / week (30 mins or less)

Exercise - twice / week (30 - 60 mins)

Exercise - twice / week (60 - 90 mins)

Exercise - twice / week (90 mins or more)

Exercise - three+ / week (30 mins or less)

Exercise - three+ / week (30 - 60 mins)

Exercise - three+ / week (60 - 90 mins)

Exercise - three+ / week (90 mins or more)

Lifestyle: Extremely active

Lifestyle: Active

Lifestyle: Moderately active

Lifestyle: Sedentary

Lifestyle: Largely Sedentary

Energy level: high

Energy level: normal

Energy level: low

Personal Habits – Sleep

Sleep: less than 4 hours / day

Sleep: 4 - 6 hours / day

Sleep: 6 - 8 hours / day

Sleep: 8 - 10 hours / day

Sleep: 10 - 12 hours / day

Sleep: more than 12 hours / day

Sleep pattern: Normal

Sleep pattern: Insomnia

Sleep pattern: Night frights

Sleep pattern: Fitful

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, do hereby designate _____ to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-l(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee healthcare benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from the above named doctor.

These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

_____ _____

Patient's Signature Patient's Signature (Image)

_____

Patient's Printed Name

_____

Date

ASSIGNMENT OF BENEFITS

I, _____, do hereby assign all my benefits and rights from the following insurance companies:

_____

_____

_____

to the medical provider designated below. I assign all rights to pursue payments for services rendered to me by this medical provider and the medical provider may proceed against said insurance company obligated to make payment to me or to this medical provider for services rendered to me. In the event that the insurance company refuses to make such payment upon demand, I expressly give permission for a cause of action to be brought in my name as assigned.

A photocopy of this assignment may be valid as if it were an original.

I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that if another attorney is substituted in this matter, the new attorney honor the within assignment.

_____

Patient's Signature

_____

Patient's Printed Name

_____ _____

Medical Provider Provider Address

_____

Date

DATA COLLECTION

Collection of the following information is encouraged by Federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

RACE	Decline Response	Native Hawaiian or Pacific Islander
	American-Indian or Alaska Native	White
	Asian	Other
	Black or African American	

ETHNICITY	Decline Response
	Hispanic or Latino
	Not Hispanic or Latino

PREFERRED LANGUAGE	English
	Spanish