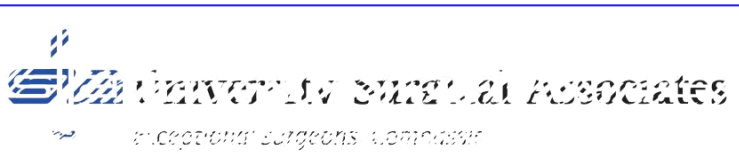
Patient Registration Form



Visit Information

Type of Visit ☐ Personal ☐ Worker's Comp ☐ Other Accident ☐ MVA/Auto Accident

Referral Source ☐ Physician ☐ Relative/Friend ☐ Online ☐ Advertisement ☐ Yellow Pages ☐ Other

Referring Physician _____ Street Address _____

City _____ State _____ Zip _____ Office Phone _____

Patient Information

Name (First, Middle, Last) _____ Date of Birth _____ SS# _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Employer's Name _____ Employer's Address _____

City _____ State _____ Zip _____ Employer's Phone _____

Spouse Information

Name (First, Middle, Last) _____ Date of Birth _____ SS# _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Employer's Name _____ Employer's Address _____

City _____ State _____ Zip _____ Employer's Phone _____

Emergency Contact

Name (First, Middle, Last) _____ Relationship to Patient _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Employer's Name _____ Employer's Address _____

City _____ State _____ Zip _____ Employer's Phone _____

Billing Information

Patient Name:

Billing Name | Date of Birth | SS#

Street Address | Apt. #

City | State | Zip | Home Phone | Cell Phone

Employer's Name | Employer's Address

City | State | Zip | Employer's Phone

Insurance Information

Primary Insurance

Name of Insurance

Street Address

Address #2

City | State | Zip

Phone | Fax

Effective Date | Group #

Policy #

Primary Subscriber (Policy Holder)

Relationship to Patient

Name

Address | Apt. #

City | State | Zip

Home Phone | Cell Phone

Date of Birth | SS#

Employer's Name

Employer's Address

City | State | Zip

Secondary Insurance

Name of Insurance

Street Address

Address #2

City | State | Zip

Phone | Fax

Effective Date | Group #

Policy #

Secondary Subscriber (Policy Holder)

Relationship to Patient

Name

Address | Apt. #

City | State | Zip

Home Phone | Cell Phone

Date of Birth | SS#

Employer's Name

Employer's Address

City | State | Zip

Reason for Visit

Patient Name:

Patient Name (First, Middle, Last)

Referring Physician

Current condition/complaint

OFFICE USE ONLY

(RUE) BP

Height

(LUE) BP

Weight

Heart Rate

Temp.

Resp. Rate

Allergies

Reactions

History of present illness

Previous Hospital Admissions/Surgeries/Serious Injuries

Current Medications

Patient Name:

Patient Medical History

Diabetes	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Heart issues	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No
Bleeding tendancy	☐ Yes	☐ No
Recent infections	☐ Yes	☐ No
Sexually transmitted disease	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Hepatits	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Family history of polyps	☐ Yes	☐ No
Family history of cancer	☐ Yes	☐ No
Family history of breast cancer	☐ Yes	☐ No

Patient Social History

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco ☐ Never ☐ Previously, but quit Current packs/day

Use of Drugs ☐ Never Type/Frequency

Family Medical History

	Age	Diseases	Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			

Review of Systems

Patient Name: _____

Please check appropriate answer

CONSTITUTIONAL SYSTEM

- Good general health ☐ Yes ☐ No
- Recent weight change ☐ Yes ☐ No
- Fever ☐ Yes ☐ No
- Fatigue ☐ Yes ☐ No
- Headaches ☐ Yes ☐ No

EYES

- Eye disease or injury ☐ Yes ☐ No
- Wear glasses/contact lenses ☐ Yes ☐ No
- Blurred or double vision ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No

EARS/NOSE/THROAT

- Hearing loss/ringing ☐ Yes ☐ No
- Chronic sinus problems ☐ Yes ☐ No
- Nose bleeds ☐ Yes ☐ No
- Bad breath or bad taste ☐ Yes ☐ No
- Sore throat/voice change ☐ Yes ☐ No

CARDIOVASCULAR

- Heart problems ☐ Yes ☐ No
- Chest pain or angina ☐ Yes ☐ No
- Palpitation ☐ Yes ☐ No
- Shortness of breath walking ☐ Yes ☐ No
- Shortness of breath lying ☐ Yes ☐ No
- Swelling of feet/ankles/hands ☐ Yes ☐ No
- Varicose veins ☐ Yes ☐ No

RESPIRATORY

- Chronic coughing ☐ Yes ☐ No
- Coughing up blood ☐ Yes ☐ No
- Shortness of breath ☐ Yes ☐ No
- Asthma or wheezing ☐ Yes ☐ No

MUSCULOSKELETAL

- Joint pain/stiffness/swelling ☐ Yes ☐ No
- Weakness in muscles/joints ☐ Yes ☐ No
- Muscle pain or cramps ☐ Yes ☐ No
- Cold extremities ☐ Yes ☐ No
- Difficulty walking ☐ Yes ☐ No

GASTROINTESTINAL

- Loss of appetite ☐ Yes ☐ No
- Change in bowel movements ☐ Yes ☐ No
- Painful bowel movements ☐ Yes ☐ No
- Constipation ☐ Yes ☐ No
- Rectal bleeding/blood in stool ☐ Yes ☐ No
- Abdominal pain/heartburn ☐ Yes ☐ No
- Peptic ulcer ☐ Yes ☐ No
- Unable to restrain stools ☐ Yes ☐ No
- Colon cancer ☐ Yes ☐ No
- Polyps ☐ Yes ☐ No
- Nausea or vomiting ☐ Yes ☐ No

Have you ever had the following tests:

- Colonoscopy ☐ Yes ☐ No
- Barium enima ☐ Yes ☐ No
- Flexible sigmoidoscopy ☐ Yes ☐ No

BLOOD AND LYMPH

- Slow to heal after cuts ☐ Yes ☐ No
- Bleeding/bruising tendancy ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Blood clots ☐ Yes ☐ No
- Past transfusion ☐ Yes ☐ No
- Enlarged glands ☐ Yes ☐ No

URINARY AND REPRODUCTIVE

- Frequent urination ☐ Yes ☐ No
- Burning/painful urination ☐ Yes ☐ No
- Blood in urine ☐ Yes ☐ No
- Unable to restrain/dribbling ☐ Yes ☐ No
- Kidney stones ☐ Yes ☐ No
- Male- testicle pain ☐ Yes ☐ No
- Female- pain with periods ☐ Yes ☐ No
- Female- irregular periods ☐ Yes ☐ No
- Female- vaginal discharge ☐ Yes ☐ No
- Female- breast feed ☐ Yes ☐ No
- Female- hysterectomy ☐ Yes ☐ No
- Female- ovaries removed ☐ Yes ☐ No
- Female- birth control ☐ Yes ☐ No
- Female- age started period _____

Urinary/reproductive, continued

- Female- last menstral period (date) _____
- Female- # of pregnancies _____
- Female- # of miscarriages _____
- Female- Age of first pregnancy _____
- Female- # of children _____
- Female- date of last pap smear _____

SKIN AND BREAST

- Rash or itching ☐ Yes ☐ No
- Breast pain or soreness ☐ Yes ☐ No
- Breast lump ☐ Yes ☐ No
- Breast discharge ☐ Yes ☐ No
- Had recent mammogram ☐ Yes ☐ No
- Any previous breast surgery ☐ Yes ☐ No

NEUROLOGICAL

- Frequent headaches ☐ Yes ☐ No
- Light headed or dizzy ☐ Yes ☐ No
- Convulsions or seizures ☐ Yes ☐ No
- Numbness/tingling ☐ Yes ☐ No
- Tremors ☐ Yes ☐ No
- Paralysis ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Head injury ☐ Yes ☐ No

ENDOCRINE

- Gland/hormone problem ☐ Yes ☐ No
- Thyroid disease ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Excessive thirst/urination ☐ Yes ☐ No
- Heat or cold intolerance ☐ Yes ☐ No
- Skin becoming dryer ☐ Yes ☐ No

PSYCHIATRIC

- Memory loss/confusion ☐ Yes ☐ No
- Nervousness ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- Problems sleeping ☐ Yes ☐ No