Pioneer Comprehensive Medical Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE	

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Authorization to release health information to:

Name(s)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:		

Release the following information:

❑ All Records ❑ Chart Notes ❑ Radiology Reports ❑ Operative Reports ❑ History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

Pioneer Comprehensive Medical

Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

***** Preferred Pharmacy:**

Allergies

- ❑ NONE/No Known Allergies
- ❑ Adhesive Tape
- ❑ Anesthesia
- ❑ Aspirin
- ❑ Codeine
- ❑ Dairy Products
- ❑ Iodine/Shellfish/Contrast Dye
- ❑ Latex
- ❑ Morphine
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ Wheat

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ❑ NONE of the problems listed
- ❑ allergies
- ❑ anemia
- ❑ arthritis conditions
- ❑ asthma
- ❑ arterial fibrillation
- ❑ bleeding problems
- ❑ BPH
- ❑ CAD coronary artery disease
- ❑ cancer
- ❑ cardiac arrest
- ❑ celiac disease
- ❑ chest pain
- ❑ CHF congestive heart failure
- ❑ chronic fatigue syndrome
- ❑ depression
- ❑ diabetes
- ❑ drug/alcohol abuse
- ❑ erectile dysfunction
- ❑ fibromyalgia
- ❑ Gerd
- ❑ heart disease
- ❑ high cholesterol
- ❑ hyperinsulinemia
- ❑ hyperlipidemia
- ❑ hypertension
- ❑ hypogonadism male
- ❑ hypothyroidism
- ❑ infection problems
- ❑ insomnia
- ❑ irritable bowel syndrome
- ❑ kidney problems
- ❑ menopause
- ❑ migraines/headaches
- ❑ neuropathy
- ❑ onychomycosis
- ❑ organ injury
- ❑ osteoporosis
- ❑ pulmonary embolism/blood clot in legs
- ❑ seizure disorders
- ❑ shortness of breath
- ❑ sinus conditions
- ❑ stroke
- ❑ syndrome X
- ❑ tremors
- ❑ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR