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

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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	☐ chest pain	☐ hyperlipidemia	☐ organ injury
☐ allergies	☐ CHF congestive heart failure	☐ hypertension	☐ osteoporosis
☐ anemia	☐ chronic fatigue syndrome	☐ hypogonadism male	☐ pulmonary embolism/blood clot in legs
☐ arthritis conditions	☐ depression	☐ hypothyroidism	☐ seizure disorders
☐ asthma	☐ diabetes	☐ infection problems	☐ shortness of breath
☐ arterial fibrillation	☐ drug/alcohol abuse	☐ insomnia	☐ sinus conditions
☐ bleeding problems	☐ erectile dysfunction	☐ irritable bowel syndrome	☐ stroke
☐ BPH	☐ fibromyalgia	☐ kidney problems	☐ syndrome X
☐ CAD coronary artery disease	☐ Gerd	☐ menopause	☐ tremors
☐ cancer	☐ heart disease	☐ migraines/headaches	☐ wheat allergy
☐ cardiac arrest	☐ high cholesterol	☐ neuropathy	
☐ celiac disease	☐ hyperinsulinemia	☐ onychomycosis	

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

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR