

PATIENT REGISTRATION FORM

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell: _____ Race/Ethnicity: _____

Marital Status: _____ SS#: _____ Drivers Lic#: _____

Employer: _____ Occupation: _____ Work#: _____

Spouse Name: _____ Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Insurance Company: _____

Subscriber's Name & Date of Birth: _____

Referred by: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Location: _____

Email Address: _____

Guarantee of Payment:

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

Authorization to Release Information:

I hereby authorize the physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

Assignment of Insurance Benefits:

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by the insurance. I permit a copy of the authorization to be used in place of the original.

Print Name: _____ **Signature:** _____ **Date:** _____

Medications AND Supplements AND Over the Counter Drugs

Medication	Dosage and Frequency

Past Medical History: Are you now or have you ever been treated for any of the following?

Please add any not specifically noted.

- | | | | |
|---|---------|---|---------|
| <input type="checkbox"/> Coronary Artery Disease | I25.10 | <input type="checkbox"/> Aortic Valve Disease | I35.9 |
| <input type="checkbox"/> Mitral Valve Disease | I34.09 | <input type="checkbox"/> Heart Valve Replaced? | Z95.2 |
| <input type="checkbox"/> Elevated Cholesterol/Triglycerides | E78.5 | <input type="checkbox"/> High Blood Pressure | I10 |
| <input type="checkbox"/> Type II Diabetes | E11.9 | <input type="checkbox"/> Asthma | J45.909 |
| <input type="checkbox"/> Shortness of Breath | R06.02 | <input type="checkbox"/> Sleep Apnea Syndrome | G47.33 |
| <input type="checkbox"/> Emphysema / COPD | J44.9 | <input type="checkbox"/> Gout | M10.00 |
| <input type="checkbox"/> Heartburn/GERD | K21.9 | <input type="checkbox"/> Hemorrhoids | K64.9 |
| <input type="checkbox"/> Hiatal Hernia | K44.9 | <input type="checkbox"/> Gallstones | K80.20 |
| <input type="checkbox"/> Infertility | N97.9 | <input type="checkbox"/> Low Back Pain | M54.9 |
| <input type="checkbox"/> Arthritic or Degenerative Joints | M15.0 | <input type="checkbox"/> Varicose Veins | I83.90 |
| <input type="checkbox"/> Low Thyroid Function | E03.8 | <input type="checkbox"/> Chronic Fatigue Syndrome | R53.82 |
| <input type="checkbox"/> Fibromyalgia | M79.7 | <input type="checkbox"/> Eating Disorder | F50.9 |
| <input type="checkbox"/> Depression | F32.9 | <input type="checkbox"/> Anxiety Disorder | F41.9 |
| <input type="checkbox"/> Bipolar Disorder | F31.9 | <input type="checkbox"/> Personal History Breast Cancer | Z85.3 |
| <input type="checkbox"/> Personal History of Colon Cancer | Z85.038 | <input type="checkbox"/> Hepatitis | K75.9 |
| <input type="checkbox"/> Irritable Bowel Disease | K58.9 | <input type="checkbox"/> Kidney Stones | N20.2 |
| <input type="checkbox"/> Obesity | E66.01 | <input type="checkbox"/> Other _____ | |

Allergies: I have no known drug allergies **OR** I am allergic to the following DRUGS:

Food Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No		Latex Allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Print Name: _____ **Date:** _____

Vaccinations:

Have you received the following vaccinations? Please include the date.

Tetanus, Diphtheria & Pertussis (Tdap) Yes No _____ Varicella Yes No _____
 Pneumonia Booster (Pevnar) Yes No _____ Flu Yes No _____
 Pneumonia (Pneumovax) Yes No _____ HPV (Gardasil) Yes No _____
 Meningitis (Menactra) Yes No _____ Shingles (Zostavax) Yes No _____
 Other: _____

Women:

Have you ever been pregnant? Yes No How many pregnancies? _____
 Deliveries? _____ Miscarriages? _____ C-Sections? _____
 When was your last? Mammogram _____ PAP/ Gyn Exam _____ Bone Density _____
 Colonoscopy _____ Menopausal Age _____ LMP _____
 Have you ever used hormone replacement therapy? Yes No

Men: If you are 50 years old or older

When was your last? Prostate (rectal) exam _____ Colonoscopy _____
 Have you ever had a PSA test? Yes No

SURGICAL HISTORY - Please add any not specifically noted.

Please list any and all operations you have had in your entire life, including cosmetic or plastic surgery

OPERATION	YEAR(S)	OPERATION	YEAR(S)
Tonsillectomy / Adenoidectomy		Appendectomy	
Laparoscopic Gallbladder		Open Incision Gallbladder	
Total Abdominal Hysterectomy		Vaginal Hysterectomy	
Coronary Bypass (CABG)		Carotid Endarterectomy	
Colon / Large Intestine Surgery		Prostate Surgery / Radiation	
Breast Biopsy <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both		Mastectomy <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both	
Breast Enlargement/Reduction		Breast Reduction	
Liposuction		Tummy Tuck	
Hernia Repair		Spleen Removal	
Hip Replacement <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both		Knee Replacement <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both	
Heart Valve Replacement		Coronary Artery Stenting	
C-Section		Other:	
Other:		Other:	

Hospitalization

Name	Reason	Date

Print Name: _____ Date: _____

Family Medical History: Which of the following diseases “run in your family”. Please add anything not listed.

Disease	Family Member	Disease	Family Member
Heart Disease		High Blood Pressure	
High Cholesterol		Obesity	
Diabetes		Lung Disease	
Stroke		Kidney Disease	
Breast Cancer		Colon Cancer	
Mental Illness		Prostate Cancer	
Osteoporosis		Other	

Do you have any siblings? Yes No If so, how many sisters? _____ brothers? _____
 Are they healthy? Yes No

Social History:

What is your occupation? _____ retired? _____ student? _____

Any occupational exposure? Yes No

Do you have any children? Yes No Number of daughters? _____ sons? _____

Who Lives at home with you? Alone Spouse Family Domestic Partner Roommate

Marital status: Married Single Divorced Widow Domestic Partner

Do you have any pets? Yes No If yes, what type? _____

Do you exercise? Yes No If so, what type and how often? _____

Are/were you a victim of domestic - sexual abuse? Yes No How long? _____

Are you sexually active? Yes No

Sexual orientation: Homosexual Heterosexual Other: _____

Sexual behavior: Monogamous More than one partner

Do you use any of the following?

Substance	Amount	How Often	How Many Years
Alcohol			
Tobacco			
Recreational Drugs/Type			
Caffeine			

Personal Physicians: If you would like for us to communicate your progress with your other physicians, **please provide their names.**

Specialty	Physician Name	Phone & Fax Number
Cardiologist		
Pulmonologist		
Mental Health		
Other		

Print Name: _____ **Date:** _____

ANNUAL QUESTIONNAIRE

Patient Name: _____ Date: _____

1. Have you had a Pneumonia Vaccination? Yes No If yes, When: _____
2. Have you had a Flu Vaccination? Yes No If yes, When: _____
3. Do you have little interest or pleasure in doing things? Yes No
4. Are you feeling down, depressed or hopeless? Yes No

IF “NO” TO QUESTIONS 3 and 4, SKIP TO QUESTION #5

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several Days 1	More than Half the days 2	Everyday 3
Trouble falling or staying asleep or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television.				
Moving or speaking so slowly that other people could have noticed. Or the opposite? Being so fidgety or restless that you have been moving around a lot more than usual.				
Thoughts that you would be better off dead and/or of hurting yourself in some way.				

TOTAL SCORE _____

- | | |
|-----------------------------|--------------------------------------|
| 1-4 Minimal Depression | 15-19 Moderately Severe Depression |
| 5-9 Mild Depression | 20-27 Severe Depression |
| 10-14 Moderate Depression | |

5. Have you fallen in the past year (If 65 or older please answer)? Yes No

If yes, please complete:

- | | |
|---|--|
| <input type="checkbox"/> 1 fall with injury in the past year | <input type="checkbox"/> 2 or more falls with injury in the past year |
| <input type="checkbox"/> 1 fall without injury in the past year | <input type="checkbox"/> 2 or more falls without injury in the past year |

Review of Systems: Please check all symptoms that you frequently experience

1. General: Change in appetite Chills Fatigue Fever Weight gain Weight loss
2. Eyes: Diminished visual acuity Dry eye Eye pain Itching and redness
3. Ears/Nose/Throat: Ear pain Hoarseness Ringing in the ears Sinus trouble Sore throat
4. Endocrine: Excessive thirst Heat intolerance Frequent urination Thyroid problems
5. Respiratory: Blood in sputum Cough Shortness of breath Other: _____
6. Breast: Breast lump Breast pain Breast swelling
7. Cardiovascular: Chest pain Palpitations Other: _____
8. Gastrointestinal: Bloating Cirrhosis Gallbladder problems Abdominal Pain
 Bowel changes Constipation Diarrhea Nausea
 Rectal bleeding Vomiting
9. Hematology / Lymphatic: Anemia Bleeding problems Groin mass Easy bruising
 Swollen glands
10. Genitourinary: Blood in urine Frequent urination Painful urination Genital problems
11. Musculoskeletal: Arthritis Back problems Muscle aches Painful joints
12. Skin: Cyst Dry skin Itching Masses Rash Skin cancer Skin oozing
13. Neurological: Confusion Dizziness Headache Memory loss Tingling/Numbness
14. Psychiatric: Anxiety Depressed mood Eating disorder Suicidal thoughts

What brings you in today? _____

Patient Name (Print): _____ **Date:** _____

Physician's Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practices are available on the company’s website and paper copies are out and available in the office and that I can take one of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: _____
(Print Name)

Date: _____

Patient Signature: _____

or

Patient’s Representative: _____

Date: _____

Relationship to Patient: _____

MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- Spouse _____
- Child(ren) _____
- Other _____
- Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell number: _____

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

PATIENT REFERRAL FORM

Patient Name: _____ Date: _____

Who referred you to our practice? _____

How did hear about us? (Please check off all that apply)

- Referral from a family member/friend (Name: _____)
- Insurance Plan, Plan Directory Listing and/or Plan Website _____
- Newspaper Ad (Which newspaper?) _____
- Yellow pages _____
- Online _____
- Seminar or Lecture _____
- Other (Please explain: _____)