



MEDICAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____
 SSN# _____
 Patient Name _____
 Last Name _____
 First Name _____ Middle Initial _____
 Address _____
 City _____
 State _____ Zipcode _____
 E-mail _____
 Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Employment Status: Full Part Self N/A
 Student Status: Full Part N/A

Patient Employer/School _____
 Employer/ School Address _____
 Employer/ School Phone (____) _____
 okay to leave a message

Whom may we thank for referring you? _____

3

PHONE NUMBERS

Home (____) _____
 okay to leave a message
 Cell (____) _____
 okay to leave a message

Best time and place to reach you _____
 IN CASE OF EMERGENCY, CONTACT:
 Name _____
 Relationship to Patient _____
 Home (____) _____
 Cell (____) _____
 Work (____) _____ Ext _____

2

INSURANCE

Subscriber's Name _____
 Relationship to Patient _____
 Birthdate _____ SS# _____
 Primary Insurance Co. _____
 Group # _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Secondary Insurance Co. _____
 Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I Certify that I have insurance coverage with _____
 Name of Insurance Company(ies)

and assign directly to Dr. _____
 all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____

Name of Doctor or Clinic _____
 for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Parent, Guardian, or Personal Representative _____

Please print name of Patient, Parent, Guardian, or Personal Representative _____

Date _____ Relationship to Patient _____

4

PRIMARY CARE PHYSICIANS INFORMATION

Name: _____ Address: _____ Phone Number: _____

What is your reason for today's visit?

5

GUARANTOR/RESPONSIBLE PARTY

Name: _____ Birthdate: _____ SSN#: _____
 Relationship to Patient: _____ Address: _____
 Phone Numbers: _____
 okay to leave a message



MEDICAL HISTORY

Check (✓) symptoms you currently have or have had in the past. (All information is strictly confidential)

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Numbness
- Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arm
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulder

GENITO/URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful Urination

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

CARDIOVASCULAR

- Chest pain
- High/Low blood pressure
- Irregular/Rapid heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins

CONDITIONS

Check (✓) conditions you have or have had in the past.

- AIDS
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred visions
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision-Flashes/Halos

SKIN

- Bruise easily
- Hives
- Itching/Rash
- Change in moles
- Scars
- Sore that won't heal

MEN only

- Erection difficulties
- Lump in testicles
- Penis discharge
- Other

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you Pregnant? _____

Number of children _____

MEDICATIONS/ ALLERGIES

List medications you are currently taking _____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

HEALTH HABITS

Check (✓) which you use and how much:

- Caffeine _____
- Street Drugs _____
- Tobacco _____
- Other _____

Check (✓) if your work exposes you to:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other _____

Your occupation _____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsible to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Date