

Account # _____

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New Patient Registration

Appointment Date: _____

Appointment With: _____

Patient Information

Last Name: _____

First Name: _____

SS #: _____

Sex: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Other Phone: _____

Date of Birth: _____

Single Married Widowed Divorced

Insurance Information

Primary Insurance: _____

ID #: _____

Group #: _____

Carrier's Name: _____

Carrier DOB: _____

Relationship to patient: _____

Secondary Insurance: _____

ID #: _____

Group #: _____

Carrier's Name: _____

Carrier DOB: _____

Relationship to patient: _____

Referring Physician

Name: _____

Address: _____

Phone: _____

Fax: _____

Primary Care Physician

Name: _____

Address: _____

Phone: _____

Fax: _____

Pharmacy

Name: _____

Address: _____

Phone: _____

Fax: _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

If patient is under 18 years:

Mother's Name _____

Father's Name _____

Name _____

Date of Birth _____

Date _____

Medical History

Please indicate any and all conditions, either past or present.

Constitutional

Are you currently feeling in good health? _____

Have you experienced a recent weight loss? _____

Eyes

Red, swollen or itchy eyes _____

Ears/Nose Mouth/Throat

Difficulty swallowing _____

Difficulty hearing _____

Noises in ears/head _____

Frequent nosebleeds _____

Respiratory

Wheezing _____

Genitourinary

Pregnant _____

Breast feeding _____

Gastrointestinal

Abdominal Pain _____

Bowel habit change _____

Musculoskeletal

Joint pain or swelling _____

Limited joint movement _____

Psychiatric

Anxious _____

Depressed _____

Hematological/Lymphatic

Painful or enlarged glands _____

Bruise easily _____

Endocrine

Diabetes _____

Thyroid disease _____

Reason for today's visit: _____

Anemia

Angina/chest pain

Arthritis

Asthma

Blood clots

Blood transfusion

Cancer

Chronic headache

Emphysema

Glaucoma

Hay Fever

Head injuries

Heart disease

Mitral Valve Prolapse

Heart Murmur

Heartburn

Hepatitis

High blood pressure

High cholesterol

HIV or AIDS

Hives/ Rashes

Keloid scarring

Kidney disease

Liver disease

Pneumonia

Poor wound healing

Prolonged bleeding

Reflux

Seizures

Skin ulcers

Stomach ulcer

Stroke

Swelling/sores of ankles/feet

Tuberculosis

Other

Medications Dose/Frequency

Aspirin _____

Ibuprofen _____

Blood thinners _____

Allergies
Medication/Foods/Seasonal

Social History

Do you smoke? _____

Have you ever smoked? _____

If yes, how many years? _____

Alcohol: drinks/week _____

Recreational drugs _____

Exposure to fumes, solvents, or airborne particles _____

Occupation _____

Marital Status _____

Hobbies _____

Family History

Close relatives diagnosed with any of the following:

Cancer _____

Diabetes _____

Migraines _____

Heart disease _____

Respiratory disease _____

Bleeding disorders _____

Hearing loss _____

Surgeries

Have you had a tonsillectomy? _____

Date _____

List all MD's to receive notes:

Patient Name

Date of Birth

Patient Signature

Physician Signature

Date