

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 <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
EMAIL	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)			EMPLOYER PHONE	

SUBSCRIBER/PRIMARY INSURED'S INFORMATION		RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> 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		REFERRING 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 (family member, other health professional, attorney):			
Name(s)		ADDRESS	
CITY, STATE		ZIP	HOME PHONE DAYTIME PHONE
DATES OF SERVICE		AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)	
FROM:	TO:	<input type="checkbox"/> NEVER DATE:	
Release the following information:			
<input type="checkbox"/> All Records	<input type="checkbox"/> Chart Notes	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Operative Reports <input type="checkbox"/> History & Physicals

RELEASE OF INFORMATION		
I understand that:		
<ul style="list-style-type: none"> 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):

PATIENT MEDICAL HISTORY

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

SYMPTOMS BEGAN ON:

Painful Activities	How often?	Exercise	Work Activity	Is your condition worsening?
<input type="checkbox"/> NONE	<input type="checkbox"/> Constantly (76-100%)	<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Yes
<input type="checkbox"/> Sitting	<input type="checkbox"/> Frequently (51-75%)	<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> No
<input type="checkbox"/> Standing	<input type="checkbox"/> Occasionally (26-50%)	<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	
<input type="checkbox"/> Walking	<input type="checkbox"/> Intermittently (0-25%)	<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	
<input type="checkbox"/> Bending				
<input type="checkbox"/> Lying Down				

CHIEF COMPLAINT:

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

Injuries/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?

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