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REGISTRATION FORM

(Please Print All Information)

(NOTE: By law, the doctor cannot see you unless you complete this form; return this form to the receptionist with proof of insurance or other proof showing ability to pay; please print all information)

PATIENT INFORMATION

(Please Check)

Last Name : ______________________ ☐ Male

First Name : ______________________ ☐ Female

Middle Name : ______________________ EMAIL : ______________________

Street Address : ______________________

City : ______________ State : __________ Zip : __________

Home Phone: ______________ Work: ______________ Cell: ______________

Social Security Number: ______________ Date of Birth: ______________

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other ☐

Name of Spouse: ______________ SSN: ______________ DOB ______________

IF PATIENT IS A MINOR OR A CHILD, FILL IN PARENT INFORMATION BELOW:

Father Name: ______________________ Mother Name: ______________________

METHOD OF PAYMENT

Insurance ☐ Medicare ☐ Self Pay ☐

INSURANCE AND EMPLOYMENT INFORMATION *(You must have proof of insurance and/or ability to pay at the time of appointment)*

Name of Health Insurance **:** ______________________

Name of Insured[card holder]**:** ______________________

SSN**:** ______________________ DOB: ______________________

Relationship to Patient**:** ______________________ Employer**:** ______________________

SOCIAL HISTORY

Smoke: Packs per day: __________ **Years smoked :** __________ **Alcohol Use :** __________

FEMALES.

Last Menstrual Period: ______________________ Menopause: Yes ☐ No ☐

Number of Pregnancies: ______________________ Number of Children: ______________________

Last Pap Smear: ______________________ Last Mammogram: ______________________

Have You Had a Hysterectomy? Yes ☐ No ☐

If Yes, Were Ovaries Removed? Yes ☐ No ☐

Medications: ____

Drug Allergies?: Yes ☐ No ☐

If Yes Describe:____

Past Medical Problems :___________________________Past Operations:____________________________

Serious Injuries:____

<u>FAMILY MEDICAL HISTORY</u>: (hypertension, diabetes, stroke, heart disease, lung disease, liver disease, kidney disease, TB, cancer, what kind?)

	Yes	No	
Hypertension	☐	☐	Who?________________________
Diabetes	☐	☐	Who?________________________
Stroke	☐	☐	Who?________________________
Heart Disease	☐	☐	Who?________________________
Lung Disease	☐	☐	Who?________________________
Liver Disease	☐	☐	Who?________________________
Kidney disease	☐	☐	Who?________________________
Cancer	☐	☐	Who?________________________
Other	☐	☐	Who?________________________

I authorize release of any medical information necessary to process this appointment and related claims. By my signature below, I am also responsible for full payment of all services rendered. I certify that by penalty of law, the information contained in this registration form is true to the best of my knowledge. I further agree in the event of non-payment, to bear the cost of collection, and /or Court cost and reasonable legal fees should this be required.

Signature: ____ Date: ______________________

Patient

Signature: ____ Date: ______________________

Parents or Guardian