PATIENT REGISTRATION FORM

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)		
Social Security Number	Date of Birth (MM/DD/YYYY)	Marital Status	Sex	Referred by
Patient's Street Address	City		State	Zip
Primary Phone: Home / Cell	Alternate Phone: Home / Cell		Email Address	
Preferred Contact Method: (circle one) Phone Email	Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone	Pharmacy Address		

Patient Employment Information

Employment Status (circle one) Employed Unemployed Retired Student	Employer Name	
Occupation	Employer Phone	Work Schedule (circle one) Full Time Part Time

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relationship to Patient

Insurance and Billing

Primary Health Insurance

Insurance Company		Plan		
Plan / Policy Number	Group Number	Policy Holder's Employer		
Policy Holder's Name (as it appears on insurance card or ID)	Policy Holder's Social Security Number	Policy Holder's Date of Birth (MM/DD/YYYY)		
Policy Holder's Street Address	City	State	Zip	
Policy Holder's Phone Number	Relationship to Policy Holder			

Secondary Health Insurance

Insurance Company		Plan		
Plan / Policy Number	Group Number	Policy Holder's Employer		
Policy Holder's Name (as it appears on insurance card or ID)	Policy Holder's Social Security Number	Policy Holder's Date of Birth (MM/DD/YYYY)		
Policy Holder's Phone Number	Relationship to Policy Holder			

Responsible Party

Billing Name (if other than patient)	Phone	Relationship to Patient	
Street Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian Date

Patient Last Name _____ **DOB** _____

Patient History

Reason for Visit

What brings you to the office today?

_____

_____

_____

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name of Medication	Dosage	Frequency

Allergies

Have you ever been tested for allergies?

☐ Yes ☐ No If yes, when? _____

Have you ever had allergy shots?

☐ Yes ☐ No If yes, when? _____

Are you allergic to any of the following?

☐ Adhesive tape	☐ Latex	☐ Aspirin
☐ Iodine	☐ Codeine	☐ Antibiotics
☐ Sulfa	☐ Barbiturates	☐ Local Anesthetics

Do you have any other allergies not listed?

Allergen / Allergic Substance	Reaction

Ear, Nose & Throat Symptoms

Are you experiencing any of the following?

☐ Bleeding gums	☐ Decreased sense of smell	☐ Double vision	☐ Hoarseness	☐ Neck pain	☐ Sinus problems
☐ Blurred vision	☐ Decreased sense of taste	☐ Earaches	☐ Hearing loss	☐ Nose bleeds	☐ Snoring
☐ Clicking in ears	☐ Difficulty breathing	☐ Ear discharge	☐ Itching in ears	☐ Persistent cough	☐ Throat pain
☐ Continuous runny nose	☐ Difficulty swallowing	☐ Facial paralysis	☐ Lumps in neck	☐ Recurring sore throat	☐ Vision halos
☐ Crossed eyes	☐ Dizziness	☐ Hay fever	☐ Nasal obstruction	☐ Ringing in ears	

Past Medical History

Have you ever had any of the following?

☐ Alcoholism	☐ Back problems	☐ Ear problems	☐ Hepatitis - A, B, or C	☐ Measles	☐ Skin disorder
☐ Allergies	☐ Bleeding disorder	☐ Eating disorder	☐ High blood pressure	☐ Migraines	☐ Stomach ulcer
☐ Anemia	☐ Blood disease	☐ Epilepsy	☐ High cholesterol	☐ Osteoporosis	☐ Substance abuse
☐ Anxiety disorder	☐ Blood transfusion	☐ Glaucoma	☐ Joint disorder	☐ Pneumonia	☐ Thyroid disorder
☐ Arthritis	☐ Cancer	☐ Gout	☐ Kidney disorder	☐ Polio	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Heart disease	☐ Liver disorder	☐ Rheumatic fever	☐ Venereal disease
☐ AIDS / HIV	☐ Depression	☐ Heart problems	☐ Lung disease	☐ Stroke	

Hospitalizations & Surgeries

Reason	Date

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

Patient Last Name _____ **DOB** _____

Family Medical History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism	☐ Arthritis	☐ Cancer	☐ Glaucoma	☐ Joint disorder	☐ Psychiatric disorders
☐ Allergies	☐ Asthma	☐ Depression	☐ Heart disease	☐ Kidney disease	☐ Osteoporosis
☐ Alzheimer's / Dementia	☐ AIDS / HIV	☐ Diabetes	☐ Hepatitis	☐ Liver disorder	☐ Stroke
☐ Anemia	☐ Bleeding disorder	☐ Epilepsy	☐ High cholesterol	☐ Lung disease	☐ Substance abuse
☐ Anxiety	☐ Blood disease / disorder	☐ Genetic disorder	☐ High blood pressure	☐ Migraines	☐ Thyroid disorder

Lifestyle Factors

Smoking / Drug Use

Have you ever smoked / vaped?

☐ Yes ☐ No Number of years _____ Number of packs / cartridges per day _____

Do you smoke / vape now?

☐ Yes ☐ No Number of years _____ Number of packs / cartridges per day _____

Do you use recreational drugs?

☐ Yes ☐ No Types _____ Number of times / week _____

Alcohol / Caffeine

How much alcohol do you drink per week?

Number of drinks / week _____

How much caffeine do you drink per day?

Number of drinks / day _____