PATIENT REGISTRATION FORM

Date of Appointment: _____

Patient Information

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

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

Current Medications / Vitamins

What medications and / or vitamins are you currently taking?

Name of Medication	Dosage	Frequency
Name of Medication	Dosage	Frequency
Name of Medication	Dosage	Frequency

Allergies or Adverse Reactions

Do you have any allergies or any adverse reactions to drugs?

Allergen / Allergic Substance	Reaction
Allergen / Allergic Substance	Reaction

☐ Adhesive tape ☐ Bee stings / Insect bites ☐ Iodine ☐ Latex

Immunizations

Please indicate date of last injection

☐ Pneumonia (Date) _____
☐ Hepatitis A (Date) _____
☐ Hepatitis B (Date) _____
☐ Pertussis (Date) _____
☐ Diphtheria (Date) _____
☐ Tetanus (Date) _____
☐ Varivax (Date) _____
☐ Polio (Date) _____
☐ Influenza (Flu) (Date) _____
☐ MMR (Date) _____
☐ TB Test (Date) _____

Hospitalizations & Surgeries

Reason	Date	Reason	Date
Reason	Date	Reason	Date

Past Medical History

Have you ever had any of the following?

☐ AIDS / HIV
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bladder dysfunction
☐ Bowel irregularity
☐ Cancer
☐ Chest pain / Angina
☐ Congenital heart disease
☐ Congestive heart failure
☐ Depression
☐ Diabetes
☐ Dizziness / Fainting
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Gout
☐ Headache
☐ Hearing loss
☐ Heart attack
☐ Heart murmur
☐ Heart palpitations
☐ High blood pressure
☐ High cholesterol
☐ Liver disease
☐ Menstrual dysfunction
☐ Positive TB screening
☐ Prior blood transfusion
☐ Prostate disease
☐ Rheumatic fever
☐ Scarlet fever
☐ Sexual dysfunction
☐ Shortness of breath
☐ Stroke
☐ Thyroid disease
☐ Ulcer
☐ Venereal disease

☐ Other: _____

If you have had cancer, which type and what is your current status?

_____

Family Medical History

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

☐ Alcoholism
☐ Allergies
☐ Alzheimer's / Dementia
☐ Anemia
☐ Asthma
☐ Bleeding disorder
☐ Blindness
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Hearing loss
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Kidney disease
☐ Memory loss
☐ Mental health disorder
☐ Neurological disorder
☐ Osteoporosis
☐ Stroke / CVA
☐ TB

Patient Last Name _____ **DOB** _____

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 _____

Diet / Exercise

Do you avoid meat, dairy products, or fruits / vegetables?

☐ Yes ☐ No

Without trying, have you gained / lost 10 pounds or more in the last six months?

☐ Yes ☐ No

Do you watch your salt intake?

☐ Yes ☐ No

Do take any herbal, vitamin / mineral, or nutritional drinks or supplements?

☐ Yes ☐ No

Do you eat a special diet?

☐ Yes ☐ No

Are you worried about a possible eating disorder?

☐ Yes ☐ No

How often do you exercise?

☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

If you do exercise, what type(s) of exercise do you engage in?

_____

Additional Items

Do you have any religious or cultural beliefs / values we should be aware of as we provide your care?

☐ Yes ☐ No If yes, please explain: _____

_____

Do you have difficulty falling asleep?

☐ Yes ☐ No

Are you currently experiencing any stress / stressful situations?

☐ Yes ☐ No

How often do you wear your seat belt?

☐ Daily ☐ Occasionally ☐ Never

Are you exposed to blood / body fluid / HIV at work?

☐ Yes ☐ No

Other Doctors

Please list all other doctors that you are currently seeing:

Name	Reason	Name	Reason

Patient Last Name _____ **DOB** _____

Men Only

Sexual Activity

Are you sexually active?
☐ Yes ☐ No

Do you practice safe sex?
☐ Yes ☐ No

Exams & Tests

Do you perform monthly testicular self exams?
☐ Yes ☐ No

When was your last prostate-specific antigen (PSA) blood test?
Year _____

When was your last rectal exam?
Year _____

Women Only

Menstrual History

Last menstrual period
Date _____

How long does your period last?
Days _____

How long between periods?
Days / weeks _____

Menstrual flow:
☐ Light ☐ Moderate ☐ Heavy

Pain / cramps with period?
☐ Yes ☐ No

Are you in menopause?
☐ Yes ☐ No

Exams & Tests

Do you perform monthly self breast exams?
☐ Yes ☐ No

Last mammogram:
Year _____

Last pap smear:
Year _____

Sexual Activity

Are you sexually active?
☐ Yes ☐ No

Do you practice safe sex?
☐ Yes ☐ No

Pain / bleeding after sex?
☐ Yes ☐ No

If you practice safe sex, what birth control method do you use?
Method / Brand _____

Pregnancy Information

Are you pregnant or suspect you may be pregnant?
☐ Yes ☐ No

Are you planning a pregnancy?
☐ Yes ☐ No

Number of pregnancies _____

Number of live births _____

Number of miscarriages _____

Signature

Signature of person completing form

_____

Date

_____

Relationship (if other than patient)

_____