Registration Form

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

Patient Information

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_\_

Contact Information

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Mobile Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Information

Local Pharmacy Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ Fax Number \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Mail Order Pharmacy Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ Fax Number \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Payment Information

Responsible Party's Relationship to Patient: Self Spouse Child Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (if not patient)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ Sex: M F

Social Security Number: \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Holder's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number(s): \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Medical History

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

Patient Information

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Past Medical History

(circle all that apply)

High Blood Pressure

Diabetes

High Cholesterol

Cancer type\_\_\_\_\_\_\_\_

HIV

Heart Disease

Kidney Disease

Heart Attack

Stroke

Kidney Disease

Hepatitis

Thyroid Disease

Auto Immune Disease

Sleep Apnea

Anemia

Asthma/COPD

Seizures

Depression/Anxiety

Blood Clot

Please list any surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication and Supplement List

Name of Drug and Dose

Directions

Start Date

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Allergies

(circle all that apply)

Penicillin

Sulfa

Cephalosporins

Quinolones

Macrolides

NSAIDs

Aspirin

Iodine/Betadine

Adhesives

Latex

Vicodin

Codeine

Food allergies: \_\_\_\_\_\_\_\_\_

Seasonal allergies

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History

(circle all that apply)

Disease Relation to Patient

High Blood Pressure Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Diabetes Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

High Cholesterol Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Cancer type\_\_\_\_\_\_\_\_ Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Heart Disease Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Blood Clot Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Kidney Disease Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Heart Attack Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Stroke Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Kidney Disease Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Thyroid Disease Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Auto Immune Disease Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Depression/Anxiety Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Circulation Problems Mother Father Sibling Grandparent Other\_\_\_\_\_\_\_\_

Social History

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? yes no How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you smoke in the past? yes no How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? yes no How many drinks per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consume caffeine? yes no How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? yes no What type and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Maintenance

(When was your last...)

Routine Physical \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Screening Blood Work \_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pap Smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEXA scan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_