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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): _____-_____-_____ _____-_____-_____

Castello Wellness
Dr Greg Castello DO
Erin Valentino PA-C
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Medical History

Today's Date: ____/____/_____

Patient Information

Patient Name: _____ Date of Birth: ____/____/_____

Past Medical History

(circle all that apply)

High Blood Pressure	Heart Attack	Anemia
Diabetes	Stroke	Asthma/COPD
High Cholesterol	Kidney Disease	Seizures
Cancer type_____	Hepatitis	Depression/Anxiety
HIV	Thyroid Disease	Blood Clot
Heart Disease	Auto Immune Disease	
Kidney Disease	Sleep Apnea	

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.		

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Allergies

(circle all that apply)

Penicillin	NSAIDs	Vicodin
Sulfa	Aspirin	Codeine
Cephalosporins	Iodine/Betadine	Food allergies: _____
Quinolones	Adhesives	Seasonal allergies
Macrolides	Latex	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 _____

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