

**PATIENT REGISTRATION FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ SS#: \_\_\_\_\_ Drivers Lic #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_  
Spouse Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Primary Insurance Company: \_\_\_\_\_  
Subscriber's Name & Date of Birth: \_\_\_\_\_  
Primary Care Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_  
Pharmacy Location: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Guarantee of Payment:**

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

**Authorization to Release Information:**

I hereby authorize the physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

**Assignment of Insurance Benefits:**

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by the insurance. I permit a copy of the authorization to be used in place of the original.

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Surgical History - Please add any not specifically noted.**

Please list any and all operations you have had in your entire life, including cosmetic or plastic

OPERATION	YEAR(S)	OPERATION	YEAR(S)
Tonsillectomy / Adenoidectomy		Appendectomy	
Laparoscopic Gallbladder		Open Incision Gallbladder	
Total Abdominal Hysterectomy		Vaginal Hysterectomy	
Coronary Bypass (CABG)		Carotid Endarterectomy	
Colon / Large Intestine Surgery		Prostate Surgery	
Breast Biopsy <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both		Mastectomy <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both	
Breast Enlargement		Breast Reduction	
Liposuction		Tummy Tuck	
Hernia Repair		Spleen Removal	
Hip Replacement <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both		Knee Replacement <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both	
Heart Valve Replacement		Coronary Artery Stenting	

**Family Medical History:** Which of the following diseases “run in your family”.

Please add anything not listed.

Disease	Family Member	Disease	Family Member
Heart Disease		High Blood Pressure	
High Cholesterol		Obesity	
Diabetes		Lung Disease	
Stroke		Kidney Disease	
Breast Cancer		Colon Cancer	
Bleeding Problems		Prostate Cancer	
Other:		Other	

**Social History**

Do you have any children?  Yes  No If so, how many? \_\_\_\_\_

Are you disabled?  Yes  No If so, why? \_\_\_\_\_

Who Lives at home with you?  Alone  Spouse  Family  Domestic Partner  Roommate

Do you have any pets?  Yes  No If yes, what type? \_\_\_\_\_

Do you exercise?  Yes  No If so, what type and how often? \_\_\_\_\_

Do you use any of the following?

Substance	Amount	How Often	How Many Years
Alcohol			
Tobacco			
Street Drugs / Type			
Caffeine			

**Personal Physicians:** If you would like for us to communicate your progress with your other physicians, **please provide their names.**

Specialty	Physician Name	Phone & Fax Number
Cardiologist		
Pulmonologist		
Mental Health		
Other		

**Review of Systems:** Please check all symptoms that you frequently experience

1. General:  Change in appetite  Chills  Fatigue  Fever  Weight gain  Weight loss
  2. Eyes:  Diminished visual acuity  Dry eye  Eye pain  Itching and redness
  3. Ears/Nose/Throat:  Ear pain  Hoarseness  Ringing in the ears  Sinus trouble  Sore throat
  4. Endocrine:  Excessive thirst  Heat intolerance  Frequent urination  Thyroid problems
  5. Respiratory:  Blood in sputum  Cough  Shortness of breath  Other: \_\_\_\_\_
  6. Breast:  Breast lump  Breast pain  Breast swelling
  7. Cardiovascular:  Chest pain  Palpitations  Other: \_\_\_\_\_
  8. Gastrointestinal:  Bloating  Cirrhosis  Gallbladder problems  Abdominal Pain  
 Bowel changes  Constipation  Diarrhea  Nausea  
 Rectal bleeding  Vomiting
  9. Hematology / Lymphatic:  Anemia  Bleeding problems  Groin mass  Easy bruising  
 Swollen glands
  10. Genitourinary:  Blood in urine  Frequent urination  Painful urination  Genital problems
  11. Musculoskeletal:  Arthritis  Back problems  Muscle aches  Painful joints
  12. Skin:  Cyst  Dry skin  Itching  Masses  Rash  Skin cancer  Skin oozing
  13. Neurological:  Confusion  Dizziness  Headache  Memory loss  Tingling/Numbness
- Psychiatric:  Anxiety  Depressed mood  Eating disorder  Suicidal thoughts

**Patient Name (Print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ANNUAL QUESTIONNAIRE**

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

1. Have you had a Pneumonia Vaccination?     Yes    No    If yes, When: \_\_\_\_\_
2. Have you had a Flu Vaccination?         Yes    No        If yes, When: \_\_\_\_\_
3. Do you have little interest or pleasure in doing things?     Yes    No
4. Are you feeling down, depressed or hopeless?                     Yes    No

**IF “NO” TO QUESTIONS 3 and 4, SKIP TO QUESTION #5**

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

	Not at all 0	Several Days 1	More than Half the days 2	Everyday 3
Trouble falling or staying asleep or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television.				
Moving or speaking so slowly that other people could have noticed. Or the opposite? Being so fidgety or restless that you have been moving around a lot more than usual.				
Thoughts that you would be better off dead and/or of hurting yourself in some way.				

**TOTAL SCORE** \_\_\_\_\_

- |                             |                                      |
|-----------------------------|--------------------------------------|
| 1-4    Minimal Depression   | 15-19   Moderately Severe Depression |
| 5-9    Mild Depression      | 20-27   Severe Depression            |
| 10-14   Moderate Depression |                                      |

5. Have you fallen in the past year (If 65 or older please answer)?     Yes    No

If yes, please complete:

- |   |  |
|---|--|
| <input type="checkbox"/> 1 fall with injury in the past year    | <input type="checkbox"/> 2 or more falls with injury in the past year    |
| <input type="checkbox"/> 1 fall without injury in the past year | <input type="checkbox"/> 2 or more falls without injury in the past year |

**Acknowledgement of Receipt of Notice of Privacy Practices**

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practices are available on the company's website and paper copies are out and available in the office and that I can take one of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

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

Date: \_\_\_\_\_

(print name)

Patient Signature: \_\_\_\_\_

or

Patient's Representative: \_\_\_\_\_

Date: \_\_\_\_\_

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

**PATIENT REFERRAL FORM**

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

Which doctor will you be seeing? \_\_\_\_\_

Who referred you to our practice? \_\_\_\_\_

How did hear about us if other than doctor's office? (Please check off all that apply)

- Referral from a family member/friend (Name: \_\_\_\_\_)
- Insurance Plan, Plan Directory Listing and/or Plan Website \_\_\_\_\_
- Newspaper Ad (Which newspaper?) \_\_\_\_\_
- Yellow pages \_\_\_\_\_
- Online \_\_\_\_\_
- Seminar or Lecture \_\_\_\_\_
- Other (Please explain: \_\_\_\_\_)