Patient Registration Form

Today's Date _________/_________/_________ Check-In Time _____ _________________ _______ AM / PM

Patient Information:

Full Name (Last, First and Middle) ____

Sex: Female / Male Date of Birth ______/______/_______ Social Security # _________-_______-__________

Mailing Address ____

City ______________________________________ State ________________ Zip Code ________________

Physical Street Address ____

City ______________________________________ State ________________ Zip Code ________________

Home Phone #________________________________Cell Phone # __________________________________

Work Phone # _______________________________ Contact Preference: Home_____ Cell_____ Work____

Email Address ____

Race________________________ Ethnicity ___________________ Marital Status: ____________________

Primary Insurance:

Primary Insurance Carrier ____

ID/Cert# ______________________________________Policy/Group# ____________________________

Policy Holder Name______________________________ Relationship to patient _____________________

Sex: Female / Male Date of Birth ______/______/_______ Social Security # _________-_______-__________

Secondary Insurance:

Secondary Insurance Carrier ____

ID/Cert# ______________________________________Policy/Group# ____________________________

Policy Holder Name______________________________ Relationship to patient _____________________

Sex: Female / Male Date of Birth ______/______/_______ Social Security # _________-_______-__________

Referring Physician:

Name of Referring Physician ____

Phone Number ______________________________ Fax Number_________________________________

Emergency Contact:

Name _____________________________________ Relationship to patient ______________________

Home Phone #_______________________________ Cell Phone # ________________________________

Next of Kin:

Name _____________________________________ Relationship to patient ______________________

Home Phone #_______________________________ Cell Phone # ________________________________

Employment:

Employer Name ____

Employer Address ____

City _______________________________________ State _______________ Zip Code ________________

Employer Phone #____________________________Occupation__________________________________

Guarantor Information (If patient is a minor under 17 years of age):

Full Name (Last, First and Middle) ____

Sex: Female / Male Date of Birth ______/______/________ Social Security # ________-________-_________

Guarantor's Relationship to patient____

Current Address ____

City _______________________________________ State _______________ Zip Code________________

Home Phone #_______________________________ Cell Phone # ________________________________

Work Phone # _______________________________ Contact Preference: Home_____ Cell_____ Work____

Employer Name ____

Employer Phone#____________________________Occupation__________________________________

City _______________________________________ State _______________ Zip Code________________

HISTORY / REVIEW OF SYSTEMS

PAST MEDICAL HISTORY: Please circle yes or no.

1. Have you had any significant/ severe medical problems or injuries previously? **Yes** **No**
   If YES, please list:______________________________
2. Have you required hospitalization, had previous surgeries or broken bones? **Yes** **No**
   If YES, please list: ______________________________
   ____
   ____
3. Are you under the care of a doctor at this time? **Yes** **No**
   If YES, list care and treatment: ______________________________
4. Are you on any prescription medications or over the counter medications? **Yes** **No**
   If YES, please list name(s)/dosage: ______________________________
   ____
   ____
5. Pharmacy Name/Address: ______________________________
6. Are you allergic to any medications? **Yes** **No**
   If Yes, please list: ______________________________
7. Do you smoke? **Yes** **No** # of packs per day ______________ # of years ______________
8. Do you use smokeless tobacco? **Yes** **No**
9. Do you drink/ use alcohol? **Yes** **No** # of beers per day ______________ # of drinks per day ___________
10. Do you have a history or problems with drugs or alcohol? **Yes** **No**
11. Are you pregnant? **Yes** **No** Date of last period? ______________________________

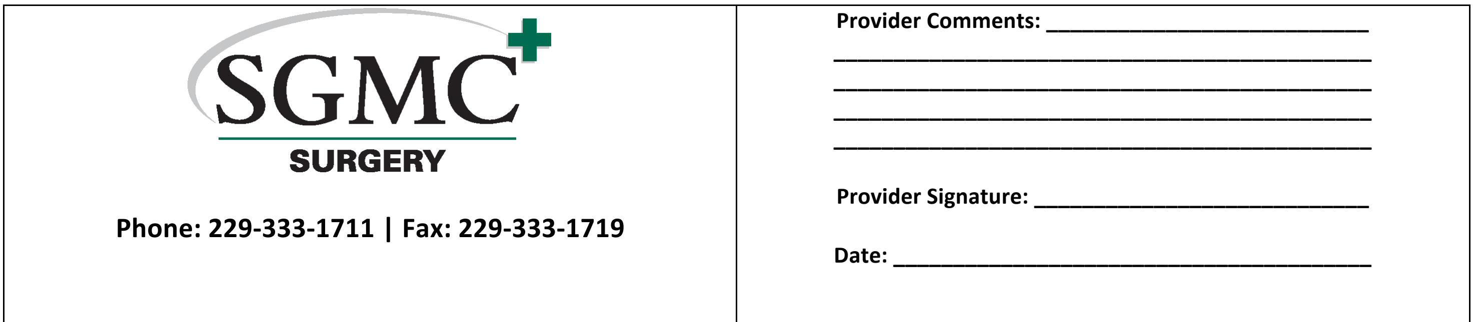
REVIEW OF SYSTEMS: Do you have a history or problems with the following? Please circle yes or no.

Sugar or Diabetes Yes No	**Vision/ eyes/ cataracts/ glaucoma** Yes No
Hearing or Ears Yes No	**Thyroid** Yes No
Lungs, Asthma, Bronchitis Yes No	**Heart, Chest pain, High Blood Pressure** Yes No
Stomach, Ulcers, Nausea, Vomiting Yes No	**Seizures: Past or Present** Yes No
Kidneys, Bladder Yes No	**Neurological problems, numbness, weakness, tingling** Yes No
Cancer Yes No	**Anemia/ Bleeding Problems, Bruise Easily, Leg Clots** Yes No
Arthritis, joint pain, stiffness Yes No	**Nerve Problems, Anxiety, Depression** Yes No
Lymph gland swelling, frequent infections Yes No	

FOR ANY YES ANSWERS PLEASE EXPLAIN:

____
____
____
____

PATIENT'S SIGNATURE: ______________________________ **DATE:** ________ / ________ /________



Phone: 229-333-1711 | Fax: 229-333-1719

Provider Comments: ______________________________
____
____
____
____

Provider Signature: ______________________________

Date: ______________________________