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	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian | Date

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

_____

_____

_____

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Allergies

Have you ever been allergy tested?

☐ Yes ☐ No When? _____

Have you ever taken allergy shots?

☐ Yes ☐ No When? _____

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Name _____ Reaction _____

ENT

Do you have any of the following?

☐ Bleeding Gums ☐ Decreased Sense of Taste ☐ Earaches ☐ Hearing Loss ☐ Nose-Bleeds ☐ Sinus Problems
☐ Blurred Vision ☐ Difficulty Breathing ☐ Ear Discharge ☐ Itching in Ears ☐ Persistent Cough ☐ Snoring
☐ Clicking in Ears ☐ Difficulty Swallowing ☐ Facial Paralysis ☐ Lumps / Knots in Neck ☐ Persistent Runny Nose ☐ Throat Pain
☐ Crossed Eyes ☐ Dizziness ☐ Hay Fever ☐ Nasal Obstruction ☐ Recurring Sore Throat ☐ Vision Halos
☐ Decreased Sense of Smell ☐ Double Vision ☐ Hoarseness ☐ Neck Pain ☐ Ringing in Ears

Past Medical History

Have you ever had any of the following?

☐ Alcoholism ☐ Back Problems ☐ Ear Problems ☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder ☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ Anemia ☐ Blood Disease ☐ Epilepsy ☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma ☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Arthritis ☐ Cancer ☐ Gout ☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems ☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Family History

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

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

Name _____ Gender _____ Age _____

Date of Appointment: _____

Review of Systems

General

- [ ] Chills
- [ ] Dizziness
- [ ] Fainting
- [ ] Fever
- [ ] Hair Loss
- [ ] Hair Growth – Excessive
- [ ] Night Sweats
- [ ] Sleeping Problems
- [ ] Thirst - Excessive
- [ ] Weight Gain
- [ ] Weight Loss

Mental Health

- [ ] Anxiety
- [ ] Depression
- [ ] Loss of Interest
- [ ] Feeling Hopeless
- [ ] Hearing Voices
- [ ] Marital Problems
- [ ] Panic Attacks
- [ ] Trouble Concentrating
- [ ] Suicide–Thoughts/Attempts

Genitourinary

- [ ] Blood in Urine
- [ ] Lack of Bladder Control
- [ ] Frequent Urination
- [ ] Painful Urination

Gastrointestinal

- [ ] Appetite Gain
- [ ] Appetite Loss
- [ ] Bloating
- [ ] Bowel Changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Intestinal Disorder
- [ ] Lactose Intolerance
- [ ] Nausea
- [ ] Rectal Bleeding
- [ ] Stomach Pain
- [ ] Vomiting
- [ ] Vomiting Blood

Neurological

- [ ] Coordination Problems
- [ ] Convulsions
- [ ] Difficulty Walking
- [ ] Learning Disabilities
- [ ] Light-headedness
- [ ] Memory Loss
- [ ] Numbness / Tingling
- [ ] Paralysis
- [ ] Seizures
- [ ] Speech Problems
- [ ] Tremors

Skin

- [ ] Chills
- [ ] Acne
- [ ] Bruise Easily
- [ ] Changes in Moles
- [ ] Dry / Sensitive Skin
- [ ] Eczema
- [ ] Hives
- [ ] Itching
- [ ] Rash
- [ ] Scars
- [ ] Sores That Won't Heal

Respiratory

- [ ] Coughing
- [ ] Coughing Up Blood
- [ ] Shortness of Breath
- [ ] Wheezing

Cardiovascular

- [ ] Chest Pains
- [ ] Irregular Heart Beat
- [ ] Circulation Problems
- [ ] Heart Palpitations
- [ ] Rapid Heartbeat
- [ ] Swelling of Ankles
- [ ] Varicose Veins

Musculoskeletal

- [ ] Back Pain
- [ ] Carpal Tunnel Syndrome
- [ ] Joint Pain
- [ ] Joint Swelling
- [ ] Neck Pain
- [ ] Shoulder Pain

Women Only

- [ ] Abnormal Pap Smear
- [ ] Bleeding between Periods
- [ ] Breast Lump
- [ ] Extreme Menstrual Pain
- [ ] Hot Flashes
- [ ] Nipple Discharge
- [ ] Painful Intercourse
- [ ] Vaginal Discharge

Other Symptoms