

PATIENT REGISTRATION

PATIENT NAME _____

BIRTHDAY _____ AGE _____ MARITAL STATUS S M D W

SOCIAL SECURITY # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____

HOME PHONE # _____ CELL PHONE # _____

EMPLOYER _____ WORK # _____

MAY WE CONTACT YOU AT WORK? YES NO

PRIMARY CARE PHYSICIAN _____

ADDRESS _____ PHONE # _____

REFERRED BY _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

SUBSCRIBER _____ DOB _____

ADDRESS IF DIFFERENT THAN ABOVE _____

ID # _____ **EMPLOYER** _____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

SECONDARY INSURANCE _____

SUBSCRIBER _____ DOB _____

ADDRESS IF DIFFERENT THAN ABOVE _____

ID # _____ **EMPLOYER** _____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

EMERGENCY CONTACT

NAME: _____ **RELATION:** _____

PHONE # _____ **WORK #** _____

HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE _____ / _____ / _____ PATIENT # _____

To help us meet all your healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date _____
 Place of birth _____
 Highest level in school _____
 Occupation _____
 Previous occupations _____
 Marital status _____
 Hobbies _____
 Exercise/recreation _____
 Habits:
 Smoking (type & amount per day) _____
 If former smoker, date quit _____
 Alcohol (type & amount per week) _____
 Caffeine (type & amount per day) _____
 Street drugs (type & amount per day) _____
 Usual weight _____
 Date of last dental exam _____
 Please list all allergies (foods, drugs, environment)

When was your last physical exam? _____
 Name of doctor _____ Phone _____
 Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: none

Please list all medicines you are currently taking (include nonprescription drugs): none

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): none

Chief Complaints

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles no yes	Migraine headaches no yes	Hives or Eczema no yes
Mumps no yes	Tuberculosis no yes	AIDS or HIV+ no yes
Chickenpox no yes	Diabetes no yes	Infectious Mono no yes
Whooping Cough no yes	Cancer no yes	Bronchitis no yes
Scarlet Fever no yes	Polio no yes	Mitral Valve Prolapse .. no yes
Diphtheria no yes	Glaucoma no yes	Stroke no yes
Smallpox no yes	Hernia no yes	Hepatitis no yes
Pneumonia no yes	Blood or Plasma no yes	Ulcer no yes
Rheumatic Fever no yes	transfusions	Kidney Disease no yes
Heart Disease no yes	Back trouble no yes	Thyroid Disease no yes
Arthritis no yes	High or low blood no yes	Bleeding tendency no yes
Venereal Disease no yes	pressure	Any other disease no yes
Anemia no yes	Hemorrhoids no yes	(please list) _____
Bladder Infections no yes	Date of last chest x-ray _____	_____
Epilepsy no yes	Asthma no yes	_____

Family History

Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Cancer.....no yes</td> <td style="width: 50%; text-align: center;">Relationship</td> </tr> <tr> <td>Tuberculosis.....no yes</td> <td>_____</td> </tr> <tr> <td>Diabetes.....no yes</td> <td>_____</td> </tr> <tr> <td>Heart Disease.....no yes</td> <td>_____</td> </tr> <tr> <td>High blood pressure.....no yes</td> <td>_____</td> </tr> </table>	Cancer.....no yes	Relationship	Tuberculosis.....no yes	_____	Diabetes.....no yes	_____	Heart Disease.....no yes	_____	High blood pressure.....no yes	_____	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Stroke.....no yes</td> <td style="width: 50%; text-align: center;">Relationship</td> </tr> <tr> <td>Epilepsy.....no yes</td> <td>_____</td> </tr> <tr> <td>Allergies.....no yes</td> <td>_____</td> </tr> <tr> <td>Anemia.....no yes</td> <td>_____</td> </tr> <tr> <td>Bleeding tendency.....no yes</td> <td>_____</td> </tr> </table>	Stroke.....no yes	Relationship	Epilepsy.....no yes	_____	Allergies.....no yes	_____	Anemia.....no yes	_____	Bleeding tendency.....no yes	_____
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Bleeding tendency.....no yes	_____																				

Family History (cont.)

(Circle "no" or "yes", leave blank if uncertain)

		Relationship	Present age, or age of death	If living, health (good, fair, poor) If deceased, cause of death
Asthma	no yes	_____	Father	_____
Chronic lung disease	no yes	_____	Mother	_____
Drug or alcohol problem	no yes	_____	Siblings	_____
Mental illness	no yes	_____	_____	_____
Leukemia	no yes	_____	_____	_____
Migraine headaches	no yes	_____	_____	_____
Obesity	no yes	_____	Spouse	_____
Thyroid Disease	no yes	_____	Children	_____
Ulcer	no yes	_____	_____	_____
Depression	no yes	_____	_____	_____
High Cholesterol	no yes	_____	_____	_____
Kidney Disease	no yes	_____	_____	_____
Glaucoma	no yes	_____	_____	_____
Gout	no yes	_____	_____	_____

Do you have now or have you had within the past year:

(Circle "no" or "yes", leave blank if uncertain)

Weakness or paralysis	no yes	Bloody sputum	no yes	Joint pain or stiffness	no yes
Tire easily or weakness	no yes	Wheezing	no yes	Swollen joints	no yes
Recent weight changes	no yes	Chest pain or discomfort	no yes	Muscle cramps or spasms	no yes
Change in appetite	no yes	Purple fingers or lips	no yes	Sleeplessness	no yes
Sensitivity to cold or heat	no yes	Swelling of hands, feet or ankles	no yes	Seizures	no yes
Persistent fever	no yes	Difficulty in breathing	no yes	Depression	no yes
Night sweats or hot flashes	no yes	Palpitations or fluttering of the heart	no yes	Memory loss	no yes
Skin rash	no yes	Leg cramps on walking or at night	no yes	Poor coordination	no yes
Skin trouble or changes	no yes	Enlarged veins	no yes	Dizziness or fainting spells	no yes
Change in nails or hair	no yes	Difficulty swallowing	no yes	A living will or advance directive	no yes
Headaches	no yes	Heartburn	no yes	Men only:	
Easy bleeding or bruising	no yes	Frequent belching	no yes	Discharge from penis	no yes
Double vision	no yes	Abdominal cramping	no yes	Pain or lump in testicles	no yes
Blurred vision	no yes	Nausea	no yes	Impotence	no yes
Eye pain	no yes	Vomiting	no yes	Women only:	
Infected eyes	no yes	Vomited or coughed up blood	no yes	Age period began	_____
Do you wear glasses or contacts	no yes	Chronic diarrhea	no yes	How many days do periods last?	_____
When was your last eye exam	_____	Chronic constipation	no yes	How many days between periods?	_____
ringing in the ears	no yes	Rectal bleeding	no yes	Is the flow heavy?	no yes
Discharge from ears	no yes	Black tarry stools	no yes	Do you bleed or spot	no yes
Ear pain	no yes	Dark urine	no yes	between periods?	_____
Decrease in hearing	no yes	Yellow jaundice	no yes	Do you have pain or cramps?	no yes
Frequent nosebleeds	no yes	Frequent urination (day)	no yes	Date of last period?	_____
Frequent colds	no yes	Frequent urination (night)	no yes	Date of last pelvic exam?	_____
Sinus trouble	no yes	Increase in thirst	no yes	Date of last mammogram?	_____
Loss of smell	no yes	Painful urination	no yes	Any itching in vaginal area?	no yes
Persistent hoarseness	no yes	Leakage of urine	no yes	Pain with intercourse?	no yes
Sore throat	no yes	Difficulty in starting urine	no yes	Type of birth control used?	_____
Sore tongue or gums	no yes	Blood in urine	no yes	Number of pregnancies	_____
Lump or discharge from breast	no yes	Lack of sex drive	no yes	Number of full term births	_____
Chronic or frequent cough	no yes	Hemorrhoids	no yes	Number of preterm births	_____
Shortness of breath	no yes	Backaches	no yes		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X _____
Signature of patient or parent if minor

Date

Physician's Comment

Physician's Signature _____

Dr. Boyd,

Would like to thank you for taking the time to complete this short questionnaire. We apologize for any inconvenience. Electronic Health Records serve as an important facilitator for collecting patient demographic data. The 2009 economic stimulus bill and 2010 health system reform bills, both strongly encourage collection of this data. Due to recent government initiatives to promote the use of electronic health records and in compliance with Meaningful Use, the reporting of the patient's racial background is now a requirement. Please complete the following information regarding the patient who is being seen today.

If you are uncomfortable answering the questions, you may select "I refuse to report".

Patient Name: _____

Date: _____

eMail: _____

Pharmacy Name/Address _____ Phone: _____

This office may ePrescribe and view my external history prescriptions: **Yes** or **No** (answer required)

How would you describe the patient's race? (Please mark an "X" in the box adjacent to the answer that best describes this.)

Place Of Birth: _____.

- Race:** _____ American Indian or Alaska Native
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ Black or African American
_____ White
_____ Hispanic
_____ Other Race
_____ Unreported/Refused to Report

- Ethnicity:**
_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ Refused to Report

- Language:**
_____ English
_____ Indian (includes Hindi & Tamil)
_____ Spanish
_____ Russian
_____ Other

Please also list your Primary Care Physician: _____

Patient/Guardian Signature: _____ Date: _____



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Dear Patient,
Welcome to our Practice!

Your exam must be scheduled 365 days from your prior exam. (Unless your insurance has changed) Please let us know.

This exam includes but is not limited to a:

- 1) Screening Pap Smear
- 2) Gonorrhea and Chlamydia Culture
- 3) Stool Hemocult (if appropriate)
- 4) Wet Mount (if indicated)
- 5) Clinical Breast Exam
- 6) Blood Work, Mammograms and Ultrasound Prescriptions (as needed).
- 7) Prescriptions for needed medications
- 8) Physical Exam

It is important that you check/call your insurance carrier for coverage and payment policies. When inquiring with your insurance carrier, ask the following questions:

“Does my contract include payment for a Well Women office visit?”

“Does my contract include payment or a yearly screening Pap smear?”

“Does my contract include payment for Gonorrhea and Chlamydia cultures?”

- Not all insurances cover screening exams and testing.
- **When/if the claim is rejected, the patient is responsible for the fee.**
- At the time of your appointment please inform us of any procedure you do not wish to have done.

I request that _____ not be performed.

Signature _____

Date _____