NEW PATIENT REGISTRATION

Patient's Name: _____ **Date of Birth:** ____/____/____

Mobile Number: _____-_____-_____ **Home Number:** _____-_____-_____

Email: _____ **Social Security:** _____-_____-_____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

Gender Assigned at Birth: _____ **Gender Identity:** _____

Employment Status: _____ **Marital Status:** _____

Sexual Orientation: _____

List any disabilities you would like us to be aware of and let us know how we can accommodate you: (long term physical, mental, intellectual, sensory, etc)

_____

_____

Preferred Pharmacy Name and Address: _____

Emergency Contact: _____ **Relationship:** _____

Phone Number: _____-_____-_____

BE SURE YOU HAVE CHANGED YOUR PCP WITH YOUR INSURANCE, IF YOU HAVE NOT, THERE IS A CHANCE THEY WILL NOT PAY FOR YOUR VISIT DEPENDING ON YOUR PLAN. IT IS YOUR RESPONSIBILITY TO UPDATE THIS AND KNOW YOUR INSURANCE POLICY REQUIREMENTS.

PRIMARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

POLICY HOLDER: _____ **RELATIONSHIP TO PATIENT:** _____

POLICY HOLDER DOB: ____/____/____

IS THIS POLICY THROUGH: (CIRCLE ONE) STATE / EMPLOYER / MARKETPLACE / VA

SECONDARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

POLICY HOLDER: _____ **RELATIONSHIP TO PATIENT:** _____

POLICY HOLDER DOB: ____/____/____

IS THIS POLICY THROUGH: (CIRCLE ONE) STATE / EMPLOYER / MARKETPLACE / VA

TERTIARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

POLICY HOLDER: _____ **RELATIONSHIP TO PATIENT:** _____

POLICY HOLDER DOB: ____/____/____

IS THIS POLICY THROUGH: (CIRCLE ONE) STATE / EMPLOYER / MARKETPLACE / VA

EDUCATION AND OCCUPATION:

Highest level of education: _____

Are you currently employed: ☐ YES ☐ NO

If yes, what is your occupation: _____

MEDICATIONS:
Please list below the medications you are currently taking, Include all prescribed medications, over the counter medications, vitamins, supplements, etc.

MEDICATION	DOSE	FREQUENCY

ALLERGIES:
Have you ever had an allergic reaction to medication, food, or any other substance? If yes, please describe:

ALLERGEN	REACTION	YEAR (APPROXIMATE)

PREVIOUS PCP: _____ PHONE NUMBER: _____-_____-_____

SPECIALISTS:

PROVIDER NAME	SPECIALTY

SURGICAL/TESTING HISTORY:

PROCEDURE	DATE(S)

HEALTH HISTORY: Please circle if you had or currently have any of the following:

ADD/ADHD	**DEVELOPMENTAL/BEHAVIORAL DISORDERS**	**LIVER DISEASE**
AIDS/HIV	**DIABETES**	**LUNG DISEASE**
ABUSE/DOMESTIC VIOLENCE	**DIFFICULTY SWALLOWING**	**MRSA EXPOSURE**
ALLERGIES	**DIVERTICULITIS**	**MENIERE'S DISEASE**
ANEMIA	**EAR OR HEARING PROBLEM**	**MENTAL DISORDER**
ANESTHESIA COMPLICATIONS	**EATING DISORDER**	**MENTAL ILLNESS**
ANXIETY	**ECZEMA**	**MUSCLE/JOINT/BONE PROBLEMS**
ARTHRITIS	**ENDOMETRIOSIS**	**OBESITY**
ASTHMA	**FIBROMYALGIA**	**OSTEOPOROSIS**
AUTISM SPECTRUM DISORDER	**GI PROBLEMS**	**OVARIAN CANCER**
BEDWETTING	**GOUT**	**POLYPS**
BIRTH DEFECTS	**HEADACHES**	**PRE-ECLAMPSIA**
BLADDER PROBLEMS	**HEART DISEASE**	**PULMONARY EMBOLISM**
BLOOD DISEASES	**HEART PROBLEMS**	**REFLUX/GERD**
BREAST CANCER	**HEPATITIS**	**SEIZURES/EPILEPSY**
BREAST PROBLEM	**HIGH CHOLESTEROL**	**SKIN PROBLEMS**
COPD	**HOSPITALIZATIONS**	**STROKE**
CANCER	**HYPERTENSION**	**THROMBOPHILIAS**
CHICKEN POX	**HYPERTHYROIDISM**	**THYROID PROBLEMS**
CHRONIC EAR INFECTIONS	**HYPOTHYROIDISM**	**TUBERCULOSIS**
CONGESTIVE HEART FAILURE	**INFERTILITY**	**VARICOSITIES**
CONSTIPATION	**KIDNEY PROBLEMS**	**VISION/EYE PROBLEM**
CORONARY ARTERY DISEASE	**KIDNEY STONES**	**OTHER: _____**

PREVENTATIVE CARE:

Have you ever had a colonoscopy/Cologuard/FIT test? ☐ YES ☐ NO

If yes, which one? _____

Date of most recent ____/____/____

FEMALE ONLY:

Have you ever had a mammogram? ☐ YES ☐ NO

If yes, date of most recent: ____/____/____

Date of Last Menstrual Period: ____/____/____

Date of Last PAP Smear: ____/____/____

Any *abnormal* PAP: ☐ YES ☐ NO Date: ____/____/____

FAMILY HISTORY: Please circle if your family members have had any of the following

DIAGNOSES	RELATION	DIAGNOSES	RELATION
Alcohol / Drug abuse		Heart Disease	
Endometrial Cancer		High Cholesterol	
Uterine Cancer		High Blood Pressure	
Arthritis		Kidney Disease	
Asthma		Ovarian Cancer	
Breast Cancer		Mental Illness	
Birth Defects		Stroke	
Cancer		Vision Loss	
COPD		Tuberculosis	
Dementia		Inflammatory Bowel Disease	
Diabetes		Immunodeficiency	
Early Death		Other:	

SUBSTANCE USE:

Do you or have you ever smoked tobacco? (select one)

☐NON-SMOKER

☐FORMER SMOKER

How many years did you smoke? _____

How much tobacco did you smoke? _____

When did you quit smoking? _____

☐CURRENT EVERYDAY SMOKER

How many years have you smoked? _____

How much tobacco do you smoke? _____

☐CURRENT SOME DAY SMOKER

How many years have you smoked? _____

How much tobacco do you smoke? _____

Do you or have you used any other forms of tobacco/nicotine? ☐ YES ☐ NO

If yes, please explain:

Electronic cigarette user _____

Chews tobacco _____

Snuff _____

Pipe smoker _____

Cigar smoker _____

What is your level of alcohol consumption?

☐NONE ☐OCCASIONAL ☐MODERATE ☐HEAVY

What is your level of caffeine consumption?

☐NONE ☐OCCASIONAL ☐MODERATE ☐HEAVY

Do you or have you use(d) any illicit or recreational drugs? ☐ YES ☐ NO

If yes, please explain:

_____

_____