

Registration Form

Please complete this form, print it out and bring to your appointment.

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ HOME PHONE: _____ CELL PHONE: _____

AGE: _____ MARITAL STATUS: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ FULL TIME PART TIME

ADDRESS: _____

WORK PHONE: _____ EMAIL: _____

OCCUPATION: _____ DRIVERS LIC#: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

SPOUSE EMERGENCY CONTACT: _____

ADDRESS: _____ HOME PHONE: _____

RELATIONSHIP TO PATIENT: _____ WORK PHONE: _____

PRIMARY MD NAME: _____ PHONE: _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY COVERAGE (IF MOTOR VEHICLE ACCIDENT-LIST MOTOR VEHICLE INSURANCE FIRST)

NAME OF INSURANCE CO: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICY HOLDER'S NAME AND RELATIONSHIP: _____

GROUP # _____ ID / POLICY: _____

SECONDARY COVERAGE (PLEASE WRITE "NONE" IF THERE IS NO SECONDARY INSURANCE)

NAME OF INSURANCE CO: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICY HOLDER'S NAME AND RELATIONSHIP: _____

GROUP #: _____ ID / POLICY: _____

CHECK IF APPLICABLE:

MOTOR VEHICLE ACCIDENT

WORK INJURY DATE OF ACCIDENT: _____

List of known allergies:

- Tobacco Type: _____
 Year begun: _____
 Still smoking: _____
 Year quit: _____
 Packs per day: _____

- Alcohol Type: _____
 How often: _____
 How much: _____
 How many years: _____

- Exercise
 None Light Moderate Heavy

Other: _____

Review of Systems: Do you have (had) the following?
Check all the appropriate boxes that apply.

- General:** Weight Gain Weight Loss Fever Hair Loss Weakness
 Other: _____

- Eyes:** Eye Strain Wear Glasses or Contact Lenses Sensitivity to Light

- Ear, Nose, Throat:** Ringing in the ears Hearing Loss Discharge or pain Dizziness Runny Nose
 Difficulty breathing through nose Sinusitis Painful teeth, gums or palate
 Growths in the mouth Pain or difficulty swallowing Hoarseness

- Cardiovascular:** Palpitations Chest pain Fainting Dizziness Varicose veins
 Difficulty climbing stairs Pain in legs Cold feet/hands
 Shortness of breath

- Respiratory:** Shortness of breath while walking Cough with or without blood Asthma/Wheezing
 Spit up blood
 Other: _____

- Gastrointestinal:** Abdominal pain Nausea Vomiting Diarrhea Hemorrhoids
 Change in shape or color of stool

- Genitourinary:** Discharge Pain Frequent urination Pain with urination

- Musculoskeletal:** Weakness Back pain Neck pain Leg pain Arm pain Shoulder pain
 Numbness Headaches
 Other: _____

- Skin:** Jaundice Dry skin Pigment change Growths Moles that have changed color, size or bleed

- Neurological:** Tremors Weakness Numbness Memory loss Confusion
 Other: _____