PATIENT REGISTRATION

PLEASE PRINT

All Information is Kept Confidential

Last Name: _____ **First Name:** _____ **M.I.** _____

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

Phone: cell( )_____ **Work: ( )** _____ **S S #:** _____

DOB: _____ **Age:** _____ **Sex:** _____ **Marital Status: S M D W D Sep**

Employer: _____ **Address:** _____ **Occupation:** _____

Emergency Contact: _____ **Phone: ( )**_____ **Relationship** _____

E mail: _____

Authorization

I hereby authorize medical care and treatment by my physician. I authorize my physician to bill my insurance for services rendered and understand that I am responsible for any portion of services my insurance may not cover under my insurance plan.

I further understand that there will be a fee if I do not give 24 hour notice to cancel any of my scheduled office visits. $50 for follow-up appointment or $75 for new appointment. Initial_____

Signature: _____ **Today's Date:**_____

MEDICAL HISTORY

Check appropriate area for your health history

☐ **Allergies (list)** _____

☐ **Heart Disease** _____ **Weight** _____

☐ **Hypertension** _____ **Height** _____

☐ **Diabetes** _____ _____

☐ **Cancer/Type** _____ _____

☐ **Respiratory Disease** _____ _____

☐ **Other (please list)** _____ _____

_____

PATIENT INFORMATION AND HEALTH SUMMARY

NAME_____/_____/_____
Last First M.I.

ADDRESS_____/_____/_____/_____
Street City State Zip Code

PHONE hm (____)_____ cell(____)_____

Date of Birth_____/_____/_____ SS#:_____-_____-_____

HT:_____ WT:_____ SEX: Male _____ Female_____

Emergency Contact:_____ Phone: (____)_____

Relationship:_____

Do you drink alcohol? ☐Yes ☐No If yes, how much and how often?_____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?_____

Do you exercise? ☐Yes ☐ No If yes, what type and how often?_____

Do you consume caffeine? ☐ Yes ☐No If yes, what type and how often?_____

Please describe your diet:_____

_____

Please list the medications and/or supplements you currently are taking on the lines below:

Medications and Dosages	Supplements
1. _____	1._____
2. _____	2._____
3. _____	3._____
4. _____	4. _____

MEDICATION ALLERGIES (please check all that apply):

☐ None known ☐ Penicillin ☐ Aspirin ☐ Sulfa ☐ Codeine

Please list any other medication and/or food allergies you have: _____

_____

Who referred you to us? _____

Please list your health care providers and the date of your last visit:

Name:_____ Name:_____

Specialty:_____ Specialty:_____

Date of Last Visit:_____ Date of Last Visit:_____

MEDICAL HISTORY

Your Past / Current Medical Conditions (please check all that apply)

- ☐ Asthma
- ☐ Cancer (type:_____)
- ☐ Chronic Fatigue Syndrome
- ☐ Depression
- ☐ Diabetes (type:_____)
- ☐ Epilepsy
- ☐ Fractures
- ☐ Headaches/Migraines
- ☐ Heart Condition (type:_____)
- ☐ High Blood Pressure
- ☐ Liver Disorder
- ☐ Osteoporosis/Osteopenia
- ☐ Arthritis
- ☐ Blood Clots (DVT, pulmonary embolism)
- ☐ Clotting Disorder
- ☐ Eating Disorder
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ High Cholesterol
- ☐ Kidney Disorder
- ☐ Thyroid Disorder
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Other:_____

Family History (please check all that apply)

☐ Cancer: type- _____

who?_____

☐ Diabetes: type-_____

who? _____

☐ Heart Disease: who?_____

☐ Alzheimer's Disease: who?_____

☐ Osteoporosis: who? _____

- Physical and mental fatigue (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)…….. _____

-Sexual problems (change in sexual desire, in sexual activity and satisfaction)…… _____

-Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)….. _____

-Joint and muscular discomfort (pain in the joints, rheumatoid complaints)…… _____

Patient Name_____ Date of Birth_____/_____/_____

Please list up to 4 health concerns that you have and would like us to help you with (Explain).

1._____

_____

_____

_____

2._____

_____

_____

_____

3._____

_____

_____

_____

4._____

_____

_____

_____

I am aware that all of the information supplied by me in this health history is kept confidential and is not released to any one without my written permission.

SIGNATURE:_____ DATE:_____

Current Medicines (Complete medicines with dosing)

Patient _____ **DOB**_____

ALLERGIES_____

Date	MEDICATION & DOSE		Instruction of how taken		D/C Date