



PATIENT REGISTRATION FORM

NAME _____ TODAY'S DATE: _____

DOB _____ AGE _____ MALE / FEMALE

STREET ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ MARITAL STATUS _____

HOME PHONE _____ CELL PHONE _____

EMERGENCY CONTACT NAME _____ PHONE NUMBER _____

EMAIL ADDRESS _____ REASON FOR TODAY'S VISIT _____

LANGUAGE (please circle) English, Indian, Spanish, Russian, other

RACE (please circle) African American, Native American, White, Hispanic, Asian other race or unreported

ETHNICITY (please circle) Hispanic or Latino, not Hispanic or Latino, or refuse to report

PRIMARY CARE PHYSICIAN

PHONE NUMBER _____ CITY, STATE _____

OBGYN Provider: _____ Where _____

Last mammo _____ Where _____ Last Pap _____ Where _____

Colonoscopy Yes / No Where _____ Provider _____ When _____

Eye doctor _____ Last exam _____

Do you have a dentist Yes / No Last exam _____ Where _____

INSURANCE CARRIER & POLICY HOLDER (if not self)

Name _____

Relationship to you: _____ D.O.B. _____



NEW PATIENT MEDICAL HISTORY

Name: _____ Today's Date: _____

Patient and Family Medical History and Behavioral Health History:

Please check off the following conditions YOU'VE had in the past:

<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Bowel/Bladder problems	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Angina	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	History of Ulcers
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Stress	<input type="checkbox"/>	Joint pain/swelling
<input type="checkbox"/>	Trauma History	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Chance of Pregnancy	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	Epilepsy/seizures	<input type="checkbox"/>	Implants plates/screws	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>		<input type="checkbox"/>	

Please check off any of the following conditions YOUR FAMILY have or has had in the past.

<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Bowel/Bladder problems	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Angina	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	History of Ulcers
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Stress	<input type="checkbox"/>	Joint pain/swelling
<input type="checkbox"/>	Trauma History	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Chance of Pregnancy	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	Epilepsy/seizures	<input type="checkbox"/>	Implants plates/screws	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>		<input type="checkbox"/>	

Patient Social Determinants of Health and Cultural Needs:

Please check off all that apply:

<input type="checkbox"/>	Living alone	<input type="checkbox"/>	Living with family	<input type="checkbox"/>	Homeless	<input type="checkbox"/>	Living in a shelter	<input type="checkbox"/>	
<input type="checkbox"/>	Employed full time	<input type="checkbox"/>	Employed part time	<input type="checkbox"/>	Retired	<input type="checkbox"/>	Disabled	<input type="checkbox"/>	Unemployed
<input type="checkbox"/>	Problems w/ Vision	<input type="checkbox"/>	Problems w/Hearing	<input type="checkbox"/>	Problems w/ Cognition	<input type="checkbox"/>		<input type="checkbox"/>	
Y /N	Do you feel safe?	Y /N	Any financial Concerns	Y /N	Do you have enough money for food?	Y /N	Have you been exposed to second hand smoke?	Y /N	Do you use drugs?
Y /N	Have you been exposed to lead paint?	Y /N	Do you drink alcoholic beverages?	Y /N	Do you smoke?	<input type="checkbox"/>		<input type="checkbox"/>	

Do you have difficulty or has anyone told you that you have difficulty interacting with others? Yes / No

Do you have social anxiety? Yes / No Do you feel isolated? Yes / No

Do you feel safe in the relationship you are in? Yes / No / NA Have you been physically hurt by your partner? Yes /No

Educational level: GED / High School / College

Please list any current or past medical conditions:

Please list any allergies (medication and environmental):

Please list all surgeries you have had and their dates:

Please List all medications that you are currently taking, including over the counter medicines

Advanced care planning:

Do you have a medical living will? Yes / No Copy given to PCP? Yes / No

Are you an organ donor? Yes / No

Signature: _____ Date: _____

Provider: _____ Date: _____