ocean state
primary care

PATIENT REGISTRATION FORM

NAME_____**TODAYS 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 _____

Preferred Pharmacy (name, address and phone #): _____

INSURANCE CARRIER & POLICY HOLDER (if not self)

Name _____

Relationship to you: _____D.O.B_____

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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:

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

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

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

Patient Social Determinants of Health and Cultural Needs:

Please check off all that apply:

	Living alone		Living with family		Homeless		Living in a shelter		
	Employed full time		Employed part time		Retired		Disabled		Unemployed
	Problems w/ Vision		Problems w/Hearing		Problems w/ Cognition				
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?				

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: _____