Medical Centers
Surgical Clinic

# Patient Registration Information Form

(Please print clearly and legibly)

Last Name: _____ First: _____ Middle:_____

Date of birth: _____/_____/_____ Social Security Number:_____/_____/_____

Sex: ☐ M ☐ F ☐ Other Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home phone: (_____) _____ Cell: (_____) _____ Work: (_____) _____

Please call: ☐ my home ☐ my work ☐ my cell
If unable to reach me :

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ _____

Email address: _____ @ _____

Patient's Employer: _____ Phone: (_____) _____

Emergency Contact: _____ Phone: (_____) _____

Primary Doctor: _____ Referred by:_____

Pharmacy: _____

<u>For Minor's only:</u>

Mother: _____Date of birth: _____/_____/_____

Father: _____Date of birth: _____/_____/_____

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Office Policies

_____ Fees—Patients are expected to pay all co-pays at the time of your visit.

_____ Nurse calls and questions—Any non-scheduling questions will be routed to the nurse line. Please leave a message with the requested information and we will return your call within one business day.

_____ Appointment times—Please arrive on time or early for your scheduled appointment. The office has a 10 minute late policy. If you are 10 or more minutes late, you will be asked to reschedule.

_____ Cancellations—Except under extenuating circumstances, we request you give at least 24 hours of notice when cancelling an appointment. Failure to do so will cause any missed appointments to be considered as a "no show".

_____ No show policy/Rescheduling—No penalty is applied to your first missed visit, but you may be charged up to a $50 no-show fee for all subsequent missed visits. Patients that "no show" for 3 appointments are subject to dismissal from our practice for non-compliance.

_____ Conduct—Verbal or physical abuse of our physician or staff will NOT be tolerated for any reason or under any circumstance.

_____ Form completion—There is a 5 business day turnaround time for FMLA or other forms needing completion. There is a $25 charge per form.

_____ Medication refills—refills need to be requested at least 3 days in advance. Ideally, these will be handled during your routine visits, but if you realize your medication needs to be refilled you may call and leave a message with the nurse requesting a refill. I understand and agree to these policies:

Signature: _____ Today's Date: ____ / ____ / _____
Must be signed by patient or legal guardian if patient is a minor.

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# Health History Form

Name: _____ Date: _____

Date of Birth: _____ Height: _____ Weight:_____

Medications you are currently taking: (Please include dosage and frequency)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies to Medications: ☐ No known drug allergies ☐ Latex Allergy

_____ _____

_____ _____

_____ _____

Past Hospitalizations and Surgeries: (Please list date, hospital, and procedure)

_____ _____

_____ _____

_____ _____

Do you have any of the following?

☐ High blood pressure ☐ Diabetes ☐ Heart Disease

☐ Reflux (heartburn) ☐ Sleep Apnea ☐ with C-PAP

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# Medical History and Review of Systems

Do you have, or have you ever had: (Please check all that apply)

Cardiac: ☐ Shortness of Breath ☐ Heart cath/stents ☐ Abnormal Stress Test/EKG
☐ Atrial fibrillation

General: ☐ Cancer ☐ HIV ☐ Headaches ☐ Weight loss
☐ Weight gain ☐ Snoring

GI:! ☐ Nausea/vomiting ☐ Throwing up blood ☐ Difficulty swallowing ☐ Constipation
☐ Diarrhea ☐ Abnormal bowel movements ☐ Blood in bowel movements
☐ Colored bowel movements

Pulmonary: ☐ Coughing up blood ☐ Wheezing ☐ Cough

Skin: ☐ Black spot ☐ Skin lesion that has changed shape/size/color
☐ Skin lesion that bleeds

Vascular: ☐ Ulcer on legs ☐ Varicose veins ☐ Spider veins

Social History: ☐ Alcohol ☐ Current ☐ Past
☐ Illicit Drugs ☐ Current ☐ Past
☐ Tobacco ☐ Current ☐ Past

Immediate Family's Health History: (State of health/medical conditions or cause of death)

Father: _____

Mother: _____

Siblings: _____

Children: _____

WOMEN ONLY:
Approximate date of last menstrual period: _____ Last mammogram: _____

Last Pap Smear: _____

Additional patient comments: _____

_____

_____

By signing below, I am stating that I have filled out the above health and medical history to the best of my knowledge. Any item left blank is to be considered answered in the negative (no or none).

Signature: _____ Date: _____