

# MEDICAL REGISTRATION AND HISTORY

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2

### INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

#### INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

\_\_\_\_\_ Name of Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

#### MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

\_\_\_\_\_ Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

\_\_\_\_\_ Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_ Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_ Date

\_\_\_\_\_ Relationship to Patient

## 3

### PHONE NUMBERS

Home (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT:**

Name \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

## 4

### FAMILY HISTORY

Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

ALIVE DECEASED	FATHER <input type="checkbox"/> <input type="checkbox"/>	Present Health or Cause of Death	MOTHER <input type="checkbox"/> <input type="checkbox"/>	Present Health or Cause of Death	SPOUSE <input type="checkbox"/> <input type="checkbox"/>	Present Health or Cause of Death
BROTHERS	NO. ALIVE	HEALTH		HOW MANY DECEASED		CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH		HOW MANY DECEASED		CAUSE OF DEATH
CHILDREN	NO. ALIVE	AGES & HEALTH		HOW MANY DECEASED		AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

Diabetes  Cancer  Bleeding tendency  Kidney disease  Tuberculosis

Heart disease  Stroke  High blood pressure  Nervous illness  Allergy  Other