

New Patient Registration Form/Updated Patient Information

Referring Source: _____

Name(First) _____ (MI) _____ (Last) _____

Date of Birth ___/___/___ Age ___ Sex ___ F ___ M Marital Status ___ S ___ M ___ D ___ W

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security: _____

Emergency Contact: _____ Phone #: _____

Assignment of Benefits

I hereby direct all payments of medical service(s) rendered by Dr. Wright. I understand that I am responsible for my deductible and/or coinsurance. I hereby authorize Dr. Wright to release information to my insurance carries concerning my illness and test(s).

Patient's Signature: _____ Date: ___/___/___

Acknowledgement of Financial Responsibilities

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment.

Insurance Information

If subscriber is not the patient please provide the following information.

Name of Insured: _____ DOB: ___/___/___

Social Security: _____

Insurance: _____ Policy #: _____

Group#: _____

PATIENTS NAME: _____

Past Medical History:

Major Problems: _____

Major Problems: _____

Major Problems: _____

Major Problems: _____

Past Surgical History:

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Past Family History:

	Circle One		Specify family member
	Yes	No	
Hypertension:	Yes	No	
Stroke/TIA:	Yes	No	
Hyperlipidemia:	Yes	No	
Coronary Heart Disease:	Yes	No	
Diabetes Mellitus, Type 1:	Yes	No	
Diabetes Mellitus, Type 2:	Yes	No	
Kidney Disease:	Yes	No	
COPD:	Yes	No	
Thyroid Disease:	Yes	No	
Breast Cancer:	Yes	No	
Prostate Cancer:	Yes	No	
Other Cancer:	Yes	No	
Colorectal Cancer:	Yes	No	
Migraine:	Yes	No	
Osteoporosis:	Yes	No	
Ulcers:	Yes	No	
Alcoholism:	Yes	No	
Depression:	Yes	No	
Other Mental Illness:	Yes	No	
Other:	Yes	No	

Social History:

Marital Status: _____

Children: Sex/Age: _____

Nutrition: _____

Exercise: _____

Sexual Activity: _____

Contraception: _____

Smoker: _____

Other Tobacco Use: _____

Alcohol: _____

Illicit drugs: _____

HIPPA PATIENT QUESTIONNAIRE

Please list family member and or person, if any whom we may inform about your general medical condition, your diagnosis and any billing question (including treatment, payment and healthcare operations).

As a reminder these will be the only people we will be able to speak to or release any information regarding your account.

Name: _____ Phone: _____

Name: _____ Phone: _____

Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? Yes or No

Please indicate if we may mail your appointment reminder/lab/x-ray results. Yes or No

This form will remain in effect until you make any changes in writing.

Patient Signature

Date

Review Of Systems (ROS)

Circle the symptom you have experienced.

General:

- Weight Loss
- Weight gain
- Fatigue
- Weakness
- Appetite
- Fever
- Chills
- Night Sweat

Skin:

- Rashes
- Pruritus
- Bruising
- Dryness
- Skin Cancer
- Other lesions

Head:

- Trauma
- Headache
- Tenderness
- Dizziness
- Syncope

Eyes:

- Changes in Vision
- Double Vision
- Glasses
- Blurring
- Diplopia
- Spots
- Inflammation
- Discharge
- Dry eyes
- Excessive tearing
- Sensitive to light

Eyes (Cont.)

- History of cataracts or glaucoma
- Last Prescription Change

Ears:

- Hearing Changing
- Ringing in ears
- Pain
- Discharge
- Dizziness
- History of ear infections

Nose:

- Sinus Problems
- Nosebleeds
- Change in Nasal drainage (Clear, Colorful)

Mouth:

- Bleeding gums
- Dental History
- Mouth sores

Throat

- Freq. Sore Throats

Respiratory:

- Chest/Breathing Pain
- Wet/Dry Cough
- Sneezing

Respiratory (Cont.)

- History of pneumonia, influenza
- Positive tuberculosis test

Cardiovascular:

- Chest Pain
- Shortness of Breath- When lying flat/with activity/middle of the night
- Murmurs

Gastrointestinal:

- Trouble Swallowing
- Heartburn
- Nausea
- Vomiting
- Blood in Vomit
- Indigestion
- Abdominal Pain
- Diarrhea
- Constipation
- Black Stool
- Red Blood Per Rectum
- Yellow Skin
- Hemorrhoids

Gynecologic:

- Age of 1st Period _____
- Pain with or Before Menses
- Irregular periods (Yes) (No)
- Contraception _____
- Last Pap smear _____
 - Normal (Yes) (No)
- Last Mammogram
 - Normal (Yes) (No)
- Pain during Intercourse
- Sexually Transmitted Disease (Yes/No)
- Number of Pregnancies _____
- Live Births _____
- Miscarriages _____
- Spotting
- Menopause
- Premenopausal-
 - Hot flashes
 - Irritability
 - Dry skin
 - Irregular periods

Genitourinary:

- Pain with urination
- Blood in Urination
- Incontinence

- Discharge
- Impotence
- Venereal Disease
- Sterility
- Hesitancy
- Urination during the night
- • Thirst/Hunger-not tolerating cold or hot temps.

Endocrine:

- Sugar in Urine
- Drastic Changes in Skin or Hair texture
- Hormone Replacement Therapy

Musculoskeletal:

- Arthritis
- Joint pains
- Joint Swelling
- Redness
- Tenderness
- Limited Joint motion
- Back pain
- Gout
- Sciatica

Blood Vessels:

- Varicose Veins
- Leg Weakness w/ activity
- History of blood clot

Blood Problems:

- History of anemia
- Bleed easily
- Bruise easily

- Swelling of Lymph nodes

Mental Health

Problems:

- Fainting Spells
- Seizures
- Weakness
- Problems w/ coordination
- Abnormal Sleep patterns
- Crying Spells
- Drug or Alcohol problems
- Sensation, Memory, or Mood problems