

**PATIENT REGISTRATION & HEALTH QUESTIONNAIRE**



PAGE #  
CHART #

NAME	MARITAL STATUS <b>S   M   W   D   SEP</b>	DATE OF BIRTH	DATE
STREET ADDRESS		CITY STATE, ZIP	
PHONE # - HOME ( )	WORK # ( )	OCCUPATION/ EMPLOYER	
SPOUSE'S NAME	DATE OF BIRTH	OCCUPATION/ EMPLOYER	PHONE # ( )
IF UNDER 18 <b>PARENT / GUARDIAN</b>			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE # ( )	ADDRESS	RELATION
S.S. #	DRIVER'S LICENSE #	REFERRED BY	

**INSURANCE & BILLING INFORMATION**

BILLING NAME (IF OTHER THAN PATIENT)	RELATIONSHIP
BILLING ADDRESS	PHONE # ( )

**PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

<b>1)</b> INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	BENEFIT CODE
	GROUP#	I.D.#
<b>2)</b> INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	BENEFIT CODE
	GROUP#	I.D.#

MEDICARE I.D.#	MEDICAID I.D.#
OTHER COVERAGE	

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct payment of surgical / medical benefits to Dr. \_\_\_\_\_ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**MEDICARE — MEDICAID**

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

*A photocopy of these assignments shall be as valid as the original.*

PATIENT NAME (please print) .....	DATE .....
PARENT / GUARDIAN (please print) .....	SIGNATURE .....

**HIPAA COMPLIANT**

# HEALTH QUESTIONNAIRE



**REASON FOR VISIT**

**FAMILY HISTORY** IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

- |                   |                   |                         |                      |
|-------------------|-------------------|-------------------------|----------------------|
| 1) Epilepsy       | 6) Thyroid        | 11) Osteoporosis        | 16) High cholesterol |
| 2) Migraine       | 7) Hayfever       | 12) Arthritis           | 17) Alcoholism       |
| 3) Mental illness | 8) Asthma         | 13) Heart disease       | 18) Hepatitis        |
| 4) Glaucoma       | 9) Anemia         | 14) Stroke              | 19) Cancer           |
| 5) Diabetes       | 10) Bleeds easily | 15) High blood pressure | 20)                  |

<b>HOSPITAL ADMISSIONS</b>	<b>YEAR</b>	<b>ILLNESS OR OPERATION</b>	<b>YEAR</b>	<b>ILLNESS OR OPERATION</b>
<i>not including pregnancies</i>				

<b>LIST ALL MEDICATIONS YOU ARE NOW TAKING - INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION</b>	<b>ALLERGIES</b>	<b>VACCINE</b>	<b>YEAR OF LAST</b>	<b>TEST / EXAM</b>	<b>YEAR OF LAST</b>
		Tetanus / Td		Rectal/stool	
		Influenza (flu)		Cholesterol	
	<b>SUPPLEMENTS</b>	Pneumonia		Eye exam	
		Hepatitis		TB test	
				Hepatitis	

**MEDICAL HISTORY** MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Decreased hearing<br><input type="checkbox"/> Ringing in ear<br><input type="checkbox"/> Ear infections - frequent<br><input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells<br><input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain<br><input type="checkbox"/> Double or blurred vision<br><input type="checkbox"/> Nose bleeds - recurrent<br><input type="checkbox"/> Sinus trouble<br><input type="checkbox"/> Sore throats - frequent<br><input type="checkbox"/> Hoarseness - prolonged<br><input type="checkbox"/> Hayfever / Allergies<br><input type="checkbox"/> Pneumonia / Pleurisy<br><input type="checkbox"/> Bronchitis / Chronic cough<br><input type="checkbox"/> Asthma / Wheezing<br><input type="checkbox"/> Shortness of breath:<br><input type="checkbox"/> on exertion <input type="checkbox"/> lying flat<br><input type="checkbox"/> Chest pain<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Heart murmur <input type="checkbox"/> Swollen ankles<br><input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations<br><input type="checkbox"/> Leg pain - when walking<br><input type="checkbox"/> Varicose veins / Phlebitis<br><input type="checkbox"/> Cold numb feet<br><input type="checkbox"/> Loss of appetite - recent | <input type="checkbox"/> Difficulty swallowing<br><input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic ulcer<br><input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Abdominal pain<br><input type="checkbox"/> Abdominal pain<br><input type="checkbox"/> Gallbladder trouble<br><input type="checkbox"/> Jaundice / Hepatitis<br><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation<br><input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's / Colitis<br><input type="checkbox"/> Inflammatory Bowel Syndrome<br><input type="checkbox"/> Bloody or tarry stools<br><input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia<br>Urination - Overactive Bladder<br><input type="checkbox"/> Overnight more than twice<br><input type="checkbox"/> More than 8 times / 24 hrs.<br><input type="checkbox"/> Urgency to urinate <input type="checkbox"/> with leakage<br><input type="checkbox"/> Decrease in force/flow <input type="checkbox"/> Painful<br><input type="checkbox"/> Stress incontinence—urine leakage with exercise / movement<br><input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones<br><input type="checkbox"/> Urine infections - frequent<br><input type="checkbox"/> Weight loss / gain <input type="checkbox"/> Height loss<br><input type="checkbox"/> Appetite<br><input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily<br><input type="checkbox"/> Blood transfusions<br><input type="checkbox"/> Cancer <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Decreased energy / endurance<br><input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease<br><input type="checkbox"/> Seizures <input type="checkbox"/> Stroke<br><input type="checkbox"/> Tremor / hands shaking<br><input type="checkbox"/> Numbness / tingling sensations<br><input type="checkbox"/> Headaches — frequent<br><input type="checkbox"/> Arthritis / Rheumatism<br><input type="checkbox"/> Back pain - recurrent<br><input type="checkbox"/> Bone fracture / joint injury<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Foot pain <input type="checkbox"/> Gout<br><input type="checkbox"/> Rashes <input type="checkbox"/> Hives<br><input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema<br><input type="checkbox"/> Concentration prob <input type="checkbox"/> Sleep problems<br><input type="checkbox"/> Depression <input type="checkbox"/> Nervousness<br><input type="checkbox"/> Agitation <input type="checkbox"/> Memory loss<br><input type="checkbox"/> Moodiness <input type="checkbox"/> Suicidal thoughts<br><input type="checkbox"/> Phobias <input type="checkbox"/> Mental illness<br><input type="checkbox"/> Feelings of worthlessness<br><input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> Chickenpox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps<br><input type="checkbox"/> Measles <input type="checkbox"/> German measles<br><input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes<br><input type="checkbox"/> AIDS / HIV <input type="checkbox"/> STD | <input type="checkbox"/> Sexual problems / enjoyment<br><input type="checkbox"/> Decreased life enjoyment<br><input type="checkbox"/> Decreased work performance<br><input type="checkbox"/> Alcohol _____ oz. per week<br><input type="checkbox"/> Coffee / Tea _____ cups per day<br><input type="checkbox"/> Smoking - cig/day _____ # years year quit _____<br><input type="checkbox"/> Exercise _____<br><input type="checkbox"/> Street drugs _____<br><input type="checkbox"/> Unwanted facial hair<br>Hair loss: <input type="checkbox"/> progressive <input type="checkbox"/> recent<br><b>MALES -</b> <input type="checkbox"/> Prostate problems<br><b>FEMALES - Please complete</b><br><b>Menstrual flow:</b><br><input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain / Cramps<br>Days of flow _____ Length of cycle _____<br>Date — 1st day of last period _____<br><input type="checkbox"/> Pain / Bleeding during or after sex<br>Number of:<br>Pregnancies _____ Abortions _____<br>Miscarriages _____ Live births _____<br>Birth control method _____<br>B.C. pill (name) _____<br><input type="checkbox"/> Flushing / Menopause<br><br>Date of last Pap test _____<br><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal<br>Date of last mammogram _____<br><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
|--|--|--|--|

**NOTES**