Patient Registration Form

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of injury:

PATIENT'S PERSONAL INFORMATION ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex**: ☐ Male ☐ Female

Name:_____ _____ _____
Last Name First Name Int.

Street Address:_____ (Apt #_____) City:_____ State: _____ Zip:_____

Home Phone:(_____)_____ Work Phone: (_____)_____Cell Phone: (_____)_____

Date of Birth: _____/_____/_____ SSN _____-_____-_____ E-mail: _____

How do you wish to be addressed? _____ Fax #: (____)_____

Employer/Name of School: _____ ☐Full-time ☐Part-Time

Your occupation:_____

PATIENT'S / RESPONSIBLE PARTY INFORMATION

Responsible party:_____ Date of Birth:_____ Age: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other_____ SSN: _____-_____-_____

Responsible party's home phone: (_____)_____ Work phone: (_____)_____

Street Address:_____ (Apt #_____) City:_____ State: _____ Zip:_____

Employer's Name:_____Employer's phone: (_____)_____

Street Address:_____City:_____ State: _____ Zip:_____

PATIENT'S INSURANCE INFORMATION Please present insurance cards to receptionist. ☐ Medicare ☐ Medicaid

PRIMARY insurance company's name: _____

Name of Insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID number:_____ Group number: _____

SECONDARY insurance company's name: _____

Name of Insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance ID number:_____ Group number: _____

SPOUSE INFORMATION Spouse Name: _____ Spouse SSN: _____-_____-_____

Spouse Date of Birth: _____ Spouse Employer: _____ Work phone #:(_____)_____

Work Address:_____ State: _____ Zip:_____

EMERGENCY CONTACT

Name of person not living with you:_____ Relationship:_____

Street Address:_____ (Apt #_____) City:_____ State: _____ Zip:_____

Home Phone:(_____)_____ Work Phone: (_____)_____Cell Phone: (_____)_____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Cape Family Medical Clinic, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date:_____ Your Signature:_____

Patient Name: _____ Age: _____ Date of Birth: _____

Are you in good health at the present time, to the best of your knowledge? Yes ____ No ____

If "No", explain:_____

_____

Are you under a doctor's care at the present time? Yes ____ No ____

If "Yes", for what? _____

_____

Last Physician Seen: _____

Your Family Medical History (Tell us of your family's medical history to the best of your ability)

	Father	Mother	Brother(s)	Sister(s)	Close Relatives
Age if living?					
General Health?					
Diseases?					
Overweight?					
Cause of Death?					
High Blood Pressure?					
Kidney Disease?					
Heart Disease/Stroke?					

Your Past Medical History Circle Yes or No

Gallbladder Disorder	YES / NO		Jaundice	YES / NO
Nervous Breakdown	YES / NO		Pleurisy	YES / NO
Rheumatic Fever	YES / NO		Tuberculosis	YES / NO
Blood Transfusion	YES / NO		Pneumonia	YES / NO
Whooping Cough	YES / NO		Eating Disorder	YES / NO
Bleeding Disorder	YES / NO		Osteoporosis	YES / NO
Heart Valve Disorder	YES / NO		Thyroid Disease	YES / NO
Psychiatric Illness	YES / NO		Cancer	YES / NO
Kidneys	YES / NO		Tonsillitis	YES / NO
Scarlet Fever	YES / NO		Ulcers	YES / NO
Drug Abuse	YES / NO		Anemia	YES / NO
Arthritis	YES / NO		Gout	YES / NO
Typhoid Fever	YES / NO		Chicken Pox	YES / NO
Liver Disease	YES / NO		Lung Disease	YES / NO
Heart Disease	YES / NO		Alcohol Abuse	YES / NO
Measles	YES / NO		Other	YES / NO

PRACTITIONER SIGNATURE _____ DATE _____

MEDICAL HISTORY

Do you have frequent ear infections? ☐ YES ☐ No
Have you been told you have a hearing loss? ☐ YES ☐ No
Have you had drainage from your ears? ☐ YES ☐ No
Do you have frequent tonsillitis or sore throats? ☐ YES ☐ No

Do you wear glasses and/or contacts? ☐ YES ☐ No
Have you noticed any recent change in your vision? ☐ YES ☐ No
Do you have cataracts or glaucoma? ☐ YES ☐ No
In the past month have you had nausea or vomiting? ☐ YES ☐ No

Do you have any stomach pain? ☐ YES ☐ No
Does any medication upset your stomach? ☐ YES ☐ No
Do you have frequent constipation? ☐ YES ☐ No
Do you have pain when urinating? ☐ YES ☐ No
Have you had kidney stones? ☐ YES ☐ No

Any kidney/bladder infections in the last month? ☐ YES ☐ No
Are you being treated for anemia? ☐ YES ☐ No
Do you have a bleeding problem? ☐ YES ☐ No
Do you have a lymph gland problem? ☐ YES ☐ No

Do you have any chronic lung problems? ☐ YES ☐ No
Have you had a chest infection recently? ☐ YES ☐ No
Have you had any shortness of breath? ☐ YES ☐ No
Have you been treated for asthma? ☐ YES ☐ No

Have you had chest pain? ☐ YES ☐ No
Are you being treated for high blood pressure? ☐ YES ☐ No
Do you have any history of high blood pressure? ☐ YES ☐ No
Have you had phlebitis or blood clots in your legs? ☐ YES ☐ No
Do you have any history of feet swelling? ☐ YES ☐ No
Do you have a history of diabetes? ☐ YES ☐ No
Do you have a history of heart disease? ☐ YES ☐ No

Have you had any serious injuries to your joints? ☐ YES ☐ No
Have you had any broken bones? ☐ YES ☐ No
Are you thirsty more than normal? ☐ YES ☐ No
Do you frequently urinate? ☐ YES ☐ No

Do you have frequent headaches? ☐ YES ☐ No
Have you had seizures? ☐ YES ☐ No
Have you had problems with drugs/alcohol? ☐ YES ☐ No
Have you been treated for depression? ☐ YES ☐ No

Do you have hives? ☐ YES ☐ No
Do you have hay fever? ☐ YES ☐ No
Have you had any numbness or tingling? ☐ YES ☐ No
Have you had any paralysis? ☐ YES ☐ No
Have you recently lost/gained significant weight? ☐ YES ☐ No

Do you have night sweats/chills or fever? ☐ YES ☐ No
Do you have a history of sleep apnea? ☐ YES ☐ No
Have you had skin cancer? ☐ YES ☐ No
Do you bruise easily? ☐ YES ☐ No
Have you been diagnosed with arthritis? ☐ YES ☐ No

Major medical problems? ☐ YES ☐ No
If so, explain: _____
_____
_____

Have you had any major surgeries? ☐ YES ☐ No
If so, list type and date: _____
_____
_____

Have you been hospitalized? ☐ YES ☐ No
Explain: _____
_____

Have you had an injury requiring physician care? ☐ YES ☐ No
Explain: _____
_____

Do you smoke? ☐ YES ☐ No
If yes, how many per day? _____
How many cigars per day? _____
Number of years you have smoked? _____

Do you use other tobacco? _____Snuff
_____Chewing tobacco

Number of years you have used tobacco? _____

When was your last tetanus shot? _____

Are you allergic to any medications? ☐ YES ☐ No
If yes, please list: _____
_____

ARE YOU PREGNANT? _____

Are you taking any medication(s) at the present time? ☐ **YES** ☐ **No**

If yes, please list ALL medications:

Drug: _____	Dosage: _____	Drug: _____	Dosage: _____
Drug: _____	Dosage: _____	Drug: _____	Dosage: _____
Drug: _____	Dosage: _____	Drug: _____	Dosage: _____
Drug: _____	Dosage: _____	Drug: _____	Dosage: _____

Patient's Signature _____ Date _____
Patient's Date of Birth _____
Practitioner's Signature _____ Date _____