Patient Registration Information

Please print and complete all sections below

PATIENT PERSONAL INFORMATION: **Marital Status** □ Single □ Married □ Divorced □ Widowed **Sex:** □ Male □ Female

Name: _____ _____ _____
Last Name *First Name* *M.I.*

Date of Birth: ____/_____/_____ **Social Security #**: _____ - _____ - _____

Home Phone: (_____) _____ - _____ **Cell:** (_____) _____ - _____

Address: _____ **Apt.#:** _____ **City:** _____ **State:** _____ **Zip:** _____

PATIENT'S/RESPONSIBLE PARTY INFORMATION *PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST*

Primary Insurance Name: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Name of Insured: _____ **Date of Birth:** _____/_____/_____
Relationship to Insured: □ Self □ Spouse □ Child □ Other

Policy #: _____ **Group #:** _____ **Copay:** _____

SECONDARY Insurance Name: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Name of Insured: _____ **Date of Birth:** _____/_____/_____
Relationship to Insured: □ Self □ Spouse □ Child □ Other
Policy #: _____ **Group #:** _____ **Copay:** _____

PATIENT REFERRAL INFORMATION: **Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____

PHARMACY INFORMATION:

Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Family First Urgent Care and any assigning physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize the 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: _____ **Signature:** _____

PATIENT HSITORY

NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY _____

OCCUPATION: _____ EDUCATION (*# of years completed):* _____

DO YOU HAVE ANY FINANCIAL CONCERNS ABOUT YOUR HEALTHCARE? □ NO □ YES _____

ALLERGIES OR ADVERSE REACTIONS

MEDICATIONS (Please specify)

_____ Reaction _____

_____ Reaction _____

_____ Reaction _____

_____ Reaction _____

□ Iodine/ Shellfish Reaction _____

□ Latex Reaction _____

FOODS (Please specify)

_____ Reaction _____

_____ Reaction _____

_____ Reaction _____

_____ Reaction _____

□ Bee Stings/Insect Bites Reaction _____

□ Adhesive Tape Reaction _____

CURRENT MEDICATIONS

Please include over the counter medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

IMMUNIZATIONS

Please indicate date of last injection

□ Pneumonia _____ □ Diphtheria _____ □ Pertussis _____

□ MMR _____ □ Polio _____ □ Tetanus _____

□ Flu _____ □ Hepatitis A _____ □ Hepatitis B _____

□ TB Test _____ □ Varivax _____

HOSPITALIZATION OR SURGERY

DATES/REASON

_____

_____

_____

_____

DATES/REASON

_____

_____

_____

_____

PAST MEDICAL HISTORY (check all that apply)

□ Headaches	□ Congenital Heart Disease	□ Liver Disease	□ Menstrual Dysfunction
□ High Blood Pressure	□ Rheumatic Fever	□ Ulcer	□ Epilepsy
□ Stroke	□ Scarlet Fever	□ Gout	□ Depression
□ High Cholesterol	□ Allergies/Hay Fever	□ Bowel Irregularity	□ Arthritis
□ Chest Pain/Angina	□ Asthma	□ Shortness of Breath	□ Dizziness/Fainting
□ Congestive Heart Failure	□ Emphysema	□ Diabetes	□ Prostate Disease
□ Heart Palpitations	□ Sexual Dysfunction	□ Anemia	□ Thyroid Disease
□ Heart Murmur	□ Venereal Disease	□ Previous Blood Transfusion	□ Bladder Dysfunction
□ Heart Attack	□ Positive TB Screening	□ Aids/HIV	□ Cancer: Type _____
	□ Glaucoma	□Hearing Loss	□ Other: _____

FAMILY HISTORY

Has any blood relative had any of the following? Check all that apply and list which family member.

□ Alzheimer's Disease _____ □ Anemia _____ □ Asthma _____ □ Bleeding Tendency _____
□Allergies _____ □ Diabetes _____ □ Alcoholism _____□ Heart Disease_____
□ High Cholesterol _____ □ Blindness _____ □ Kidney Disease _____□ Mental Health Disorder _____
□ Memory Loss _____ □ Epilepsy _____□ Osteoporosis _____ □ High Blood Pressure _____
□ Stroke/CVA _____ □ Cancer (type) _____□ Hearing Loss _____ □ Other: _____
□ Neurological Disorder _____ _____□ Tuberculosis _____

FUNCTIONAL ASSESSMENT

What is the easiest way for you to learn new things? □ Reading □ Listening □ Pictures □ Demonstration □ Video
Do you have any difficulty with writing: □ No □ Yes (explain) _____
Do you have any problems with: □ Vision □ Hearing □ Speech □ Walking □ Lifting
Do you have any religious or cultural beliefs/values we should be aware of as we provide your care: □ No □ Yes _____
_____
Are you experiencing any stress/stressful situations: □ No □ Yes (explain): _____
_____
Have you experienced any traumatic or abusive situations? □ No □ Yes (explain): _____
_____
Do you live alone? □ No □ Yes
Who is your caregiver? _____

NUTRITIONAL ASSESSMENT

Without trying, have you gained or lost 10 pounds or more in the last six months: □ No □ Yes
Are you worried about a possible eating disorder: □ No □ Yes
Do you avoid or not eat meat, dairy products or fruits/vegetables: □ No □ Yes
Do you take any herbal, vitamin/mineral, or nutritional drinks or supplements? □ No □ Yes

HABITS (check all that apply)

□ Smoke (if yes): Packs daily _____ Stopped when: _____ □ Other Tobacco Products _____
□ Coffee or other caffeinated drinks (if yes) How many daily _____ □ Diet: Salt intake _____
□ Exercise Routine (if yes) _____ Type _____ □ Snoring _____
□ Difficulty falling asleep _____ □ Special diet _____
□ Contact with blood/body fluid at work _____ □ HIV exposure /risk _____
□ Recreational/street drug use (specify) _____ □ Seat Belts _____
□ Alcohol (if yes) Type _____ □ Daily □ Weekly □ Socially

MEN ONLY

Date of last rectal exam: _____ Date of last PSA: _____
Sexually active: □ No □ Yes Monthly Testicular Self-Exam: □ No □ Yes
Practice safe sex: □ No □ Yes

WOMEN ONLY

Last menstrual period: _____ Sexually active □ Yes □ No

Age of onset: _____ □ Regular □ Irregular

Practice safe sex □ Yes □ No

Flow: □ Heavy □ Moderate □ Light

Pain/Bleeding after sex □ Yes □ No

Pain/Cramps with menses: □ Yes □ No

Pregnant □ Yes □ No

Days of flow: _____

Planning pregnancy □ Yes □ No

Length of cycle: _____

Number of pregnancies: _____

Last pap smear: _____

Number of live births: _____

Last mammogram: _____

Number of miscarriages: _____

Monthly self-breast exam: □ Yes □ No

Birth control method: _____

Flushing/Menopause: □ Yes □ No

Name of birth control: _____

OTHER DOCTORS

Name/Specialty	Reason

SIGNATURE

Signature of person completing form: _____

Date: _____ Relationship (if other than self) _____

This section to be completed by provider

To be reviewed annually and as health status changes.

Date Reviewed: _____ Provider Initials: _____ Date Reviewed: _____ Provider Initials _____

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