Naab Road Surgical Group, P.C. PATIENT REGISTRATION

Patient's Full Name ______________________ Age ____ DOB __________ ❑ Male ❑ Female
Last First MI
Address ______________________ City ______________ Zip ________
Home Phone # ______________ ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed
Cell/Pager # ______________ Social Security # ______________

Patient's Employer ______________ Occupation ______________
Address ______________________ City ______________ Zip ________
Employer's Phone # ______________
Spouse/Guarantor ______________ DOB ________ Social Security # ______________
Spouse's Employer ______________ Employer's Phone # ______________
Address ______________________ City ______________ Zip ________

If the patient is a minor (under 18) and/or In case of separated or divorced parents, the parent who requests treatment for the minor child will be the registered guarantor but both parents remain equally/jointly financially responsible.

Initial of Parent ________

Primary Care Physician (PCP) ______________ (PCP) phone # ______________

Emergency contact **(other than spouse)** ______________
Address ______________________ City ______________ Zip ________
Relationship ______________ Phone # ______________

INSURANCE INFORMATION

Primary Coverage, Name of Carrier ______________	Secondary Coverage, Name of Carrier ______________
Group # ______________	Group # ______________
Identification # ______________	Identification # ______________
Policy Holder ______________	Policy Holder ______________
Effective Date ______________	Effective Date ______________

How much is your co-pay ______________
Are you covered by Medicare? ❑ Yes ❑ No Medicare # ________ Railroad # ________
Were you injured at work? ❑ Yes ❑ No
Contact Name ______________ Number ______________

REQUEST FOR SERVICES/RELEASE OF INFORMATION

I make application to receive evaluation and/or treatment by the surgeons of the Naab Road Surgical Group, P.C. I understand that my medical condition and records are confidential and will not be released to other individuals or agencies without my express written consent. However, to provide for my care, I authorize the surgeons and staff of the Naab Road Surgical Group, P.C., by this document, to release specific medical information necessary to: schedule tests and/or surgery; receive authorization to treat; consult with referring or specialist practices; and, collect data for American Medical Association level approved studies. I release the Naab Road Surgical Group, P.C., surgeons and staff from all legal responsibility or liability that may arise from the authorization. A photostatic copy of this authorization will be as valid as the original. I agree to all of the above.

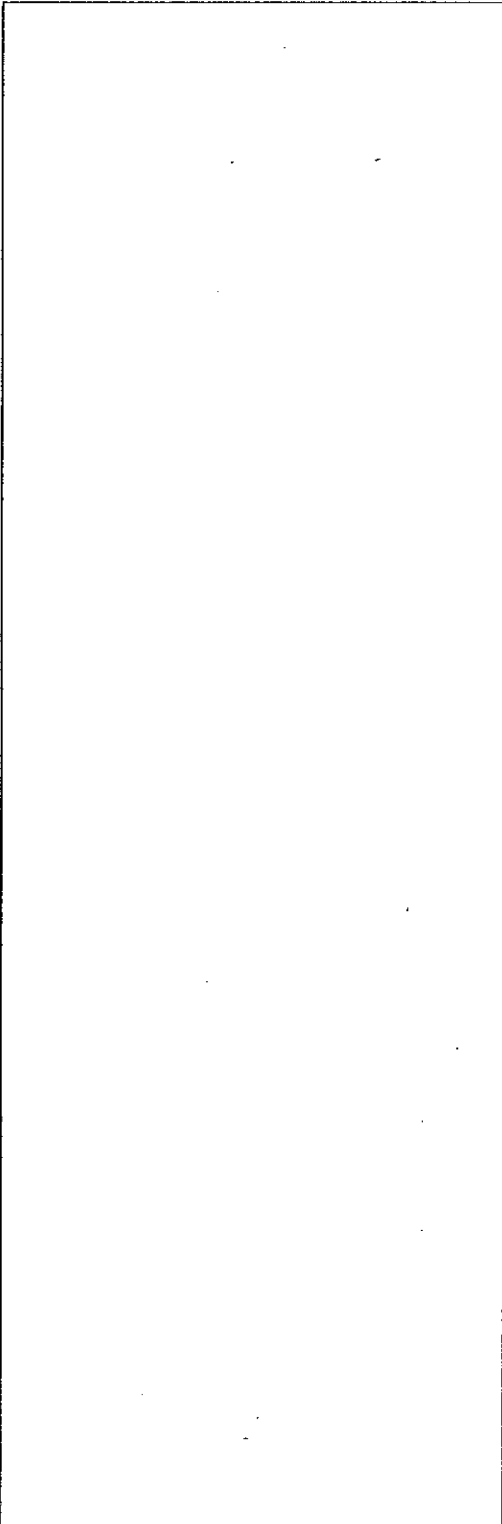
X ______________________________ ______________
Patient/parent/guardian signature Date

PATIENT HISTORY FORM

Name:_______________________ **Date of Birth:**_______________ **Date:**_______________

Referring Physician:_______________________ **Primary Care Physician:**_______________________

CHIEF COMPLAINT: (main reason for visit today)



History of Present Illness: (details of symptoms, previous tests and treatments for present illness)

Past Medical History: (other medical problems)

Past Surgical History: (previous surgical procedures and approximate dates)

Family History: (serious medical problems in close family members, both related to and unrelated to your current illness)

Social History:

Single ☐ Married ☐ Divorced ☐ Widowed ☐

Children: Yes ☐ No ☐ Number:________ Ages________________

Type of Work: _______________________

Smoking: Yes ☐ No ☐ How much:_______________________

Drink alcohol: Yes ☐ No ☐ How much:_______________________

Name:______________________ Date of Birth:____________________ Date:______________

Review Of Systems: (please check yes or no if you have any of the following symptoms)

General

	YES	NO
Fever	☐	☐
Chills	☐	☐
Weight loss	☐	☐
Weight gain	☐	☐

Eyes

	YES	NO
Glasses	☐	☐
Contacts	☐	☐
Blurry/double vision	☐	☐
Blindness	☐	☐

Ears/Nose/Throat/Mouth

	YES	NO
Deafness	☐	☐
Ear infections	☐	☐
Nosebleeds	☐	☐
Sore throat	☐	☐
Dentures	☐	☐
Sores	☐	☐

Cardiovascular

	YES	NO
Chest pain	☐	☐
Rapid heart	☐	☐
Pain walking	☐	☐
Foot swelling	☐	☐

Respiratory

	YES	NO
Cough	☐	☐
Sputum	☐	☐
Short of breath	☐	☐
Wheezing	☐	☐
Use of oxygen	☐	☐
CPAP mask	☐	☐

Gastrointestinal

	YES	NO
Abdominal pain	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Difficulty swallowing	☐	☐
Vomiting	☐	☐
Appetite loss	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Blood in stool	☐	☐
Rectal pain	☐	☐
Stool leakage	☐	☐

Genitourinary

	YES	NO
Burning w/ urination	☐	☐
Frequent urination	☐	☐
Blood in urine	☐	☐
Urine leakage	☐	☐

Musculoskeletal

	YES	NO
Arthritis	☐	☐
Bone pain	☐	☐
Muscular pain	☐	☐

Skin

	YES	NO
Rash	☐	☐
Itching	☐	☐
Bruising	☐	☐
Lumps	☐	☐
Yellow jaundice	☐	☐

Neurologic

	YES	NO
Headaches	☐	☐
Seizures	☐	☐
Weakness	☐	☐
Fainting spells	☐	☐
Numbness	☐	☐
Tremor	☐	☐

Blood/lymphatic

	YES	NO
Easy bleeding	☐	☐
Swollen glands	☐	☐

Psychological

	YES	NO
Depression	☐	☐
Anxiety	☐	☐
Addiction	☐	☐

Allergic/Immunologic

	YES	NO
Hay fever	☐	☐
Allergies	☐	☐
Immune disease	☐	☐

____
Patient Signature

____
Date

____
Physician Signature

____
Date

Name:______________________ Date of Birth:____________________ Date:_____________

Medications

Please include all prescription, over the counter and herbal remedies

Drug	Dosage	Times per day	Reason

Allergies

Please list known medicine allergies and types of reactions you have to the medication

Drug	Reaction

Reviewed by: ______________________________ Date: ______________________________

Name:______________________ Date of Birth:____________________ Date:_____________

Communication Consent

Please check the way(s) we may contact you and the appropriate phone numbers

☐ Home phone ________________________________

☐ Mobile phone ______________________________

☐ Work phone ________________________________

☐ Fax ______________________________________

☐ Other ____________________________________

May we leave a message on an answering machine for you? Yes ☐ No ☐

Is there anyone else that we may release your medical information to?

Name **Relation**

____

____

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Signature: ______________________________________ **Date:** ________________________

Printed name: ____________________________________