## PATIENT REGISTRATION

Name: _____ Social Security#: _____

Street Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Telephone (Home): _____ Work: _____

Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor

Family Doctor: _____ Referred By: _____

Patent's Employer/School: _____

Address: _____

In case of Emergency Notify: _____ Telephone: _____

## PRIMARY INSURANCE

Person Responsible for Account: _____

Relationship to patient: _____ Birth Date: _____ Social Security #: _____

Address (If different from patient): _____

Employer: _____ Telephone #: _____

Address: _____

Insurance Company Name: _____

## SECONDARY INSURANCE

Insured's Name:

Relationship to patient: _____ Birth Date: _____ Social Security #: _____

Address (If different from patient): _____

Employer: _____ Telephone #: _____

Address: _____

Insurance Company Name: _____

I certify that I, and/or my dependents, have insurance as stated above and the information provided is correct. I hereby authorize Dr. Honick to apply for benefits on my behalf for services rendered by him or by his order. I request that all payments from my insurance company be made directly to Dr. Honick. I understand I am financially responsible for all charges whether or not paid by insurance

The above named physician may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services rendered and determining insurance benefits for related services. A copy of this authorization many be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing

Signature: _____ Date: _____

Health History

Patient Name:_____ Date: _____

Age: _____ Birth Date: _____ Date Last Physical Examination: _____

What is the reason for your visit?: _____

_____

## SYMPTOMS

*Check (✓) conditions you currently have or have had in the past year*

**GENERAL**
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Loss of Sleep
- ❑ Los of Weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats

**GENITO-URINARY**
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control

**MUSCLE/JOINT/BONE**

Pain, weakness, numbness in
- ❑ Arms
- ❑ Hips
- ❑ Back
- ❑ Legs
- ❑ Feet
- ❑ Neck
- ❑ Hands Shoulders

**GASTROINTESTINAL**
- ❑ Appetite Poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

**CARDIOVASCULAR**
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

**EYE, EAR, NOSE, THROAT**
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double Vision
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision – flashes
- ❑ Vision –Halos

**SKIN**
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Changes in moles
- ❑ Rash
- ❑ Scars
- ❑ Sores that won't heal

**MEN ONLY**
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testacies
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

**WOMEN ONLY**
- ❑ Abnormal Pap smear
- ❑ Bleeding between periods
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other
- ❑ Date last menstrual period

Date last Pap smear

Have you had a mammogram?

❑ Yes ❑ No

Are you pregnant?

❑ Yes ❑ No

Number of Children

## CONDITIONS

- ❑ Aids
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorder
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Psychiatric care
- ❑ Rheumatic fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal infections
- ❑ Venereal Disease

## MEDICATIONS

_____

_____

_____

_____

## ALLERGIES

_____

_____

_____

_____

## FAMILY HISTORY

| Relationship | Age | State of Health | Age at Death | Cause of Death | Check (✓) if your blood relatives had any of the following | |
|---|---|---|---|---|---|---|
| | | | | | **Disease** | **Relationship to You** |
| Father | | | | | Arthritis, Gout | |
| Mother | | | | | Asthma, Hay Fever | |
| Brothers | | | | | Cancer | |
| | | | | | Chemical Dependency | |
| | | | | | Diabetes | |
| | | | | | Heart Disease | |
| Sisters | | | | | High Blood Pressure | |
| | | | | | Kidney Disease | |
| | | | | | Tuberculosis | |
| | | | | | Other | |

| **HOSPITALIZATIONS** | | | **Pregnancies** | | |
|---|---|---|---|---|---|
| Year | Hospital | Reason for Hospitalization and Outcome | Year of Birth | Sex | Complications, if any |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Have you ever had a blood transfusion? ❑ Yes ❑ No
If Yes please give approximate dates: ____

| Serious Illnesses | Date | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Health Habits**

Check which substances you use and describe how much you use

| | | |
|---|---|---|
| ❑ | Caffeine | |
| ❑ | Tobacco | |
| ❑ | Drugs | |
| ❑ | Alcohol | |

**Occupational**

Check if your work exposes you to the following:

| | | | |
|---|---|---|---|
| ❑ | Stress | ❑ | Hazardous Materials |
| ❑ | Heavy Lifting | ❑ | Other |

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made on this form.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____

## Advance Directive

Do you have Advance Directives/ Living Will? (For patients 18 and above)

YES NO

## Cultural/Linguistic Barriers to Care

Do you have any of the following? (Please Circle)

Poor Vision Poor Hearing

Language Barrier Religious/Cultural Barriers

None of the Above

Signature: _____ Date: _____

**Practice's Requirements**

The Practice:

(a) Is required by Federal Law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
(b) Under the Privacy Rule, we may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided under Federal Law.
(c) Is required to abide by the terms of this Privacy Notice.
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains
(e) Will distribute any revised Privacy Notice to you prior to implementation
(f) Will not retaliate against you for filing a complaint.

**EFFECTIVE DATE:** This notice is in effect as of 8/15/2015

**PATIENT ACKNOWLEDGEMENT**

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding to its terms.

Patient Signature: _____ Date: _____

Printed Patient Name: _____