The Health & Wellness Center
Dr. Secil A. Schodroski FNP-C, DNP

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape	☐ Antibiotics	☐ Latex
☐ Barbiturates (Sleeping Pills)	☐ Aspirin	☐ Iodine
☐ Codeine	☐ Sulfa	☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism	☐ Back Problems	☐ Ear Problems	☐ Hepatitis - A, B, or C	☐ Measles	☐ Skin Disorder
☐ Allergies	☐ Bleeding Disorder	☐ Eating Disorder	☐ High Blood Pressure	☐ Migraines	☐ Stomach Ulcer
☐ Anemia	☐ Blood Disease	☐ Epilepsy	☐ High Cholesterol	☐ Osteoporosis	☐ Substance Abuse
☐ Anxiety Disorder	☐ Blood Transfusion	☐ Glaucoma	☐ Joint Disorder	☐ Pneumonia	☐ Thyroid Disorder
☐ Arthritis	☐ Cancer	☐ Gout	☐ Kidney Disorder	☐ Polio	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Heart Disease	☐ Liver Disorder	☐ Rheumatic Fever	☐ Venereal Disease
☐ AIDS / HIV	☐ Depression	☐ Heart Problems	☐ Lung Disease	☐ Stroke	

Hospitalizations & Surgeries

Reason	Date

Women Only:

# of Pregnancies	# of Miscarriages	# of Abortions	# of Living

Last Pap Smear	Last Mammogram	Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism	☐ Cancer	☐ Joint Disorder
☐ Allergies	☐ Depression	☐ Kidney Disease
☐ Alzheimer's	☐ Diabetes	☐ Liver Disorder
☐ Anemia	☐ Epilepsy	☐ Lung Disease
☐ Anxiety	☐ Genetic Disorder	☐ Migraines
☐ Arthritis	☐ Glaucoma	☐ Psychiatric Disorders
☐ Asthma	☐ Heart Disease	☐ Osteoporosis
☐ AIDS/HIV	☐ Hepatitis	☐ Stroke
☐ Bleeding Disorder	☐ High Cholesterol	☐ Substance Abuse
☐ Blood Disorder	☐ High Blood Pressure	☐ Thyroid Disorder

Details:

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

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Medical Information Release Form
(HIPAA Release Form)

Name:_____ DOB:_____/_____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse_____
- ☐ Child(ren)_____
- ☐ Other_____

☐ Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell Number:_____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ other:_____

The best time to reach me is (day)_____ between(time)_____

Signature:_____ Date:_____

Submit form