Advance Biomedical Treatment Center

mHBOT PATIENT REGISTRATION FORM

Thank you for choosing our office. In order to serve you better, we need the following information. ***Please print legibly.*** *All information will be kept confidential.*

Today's Date: ____ / ____ / _____

Last Name: _____ First Name: _____ MI: _____

Birthdate (mm/dd/yr): _____ / _____ / _____ Age: _____ M / F: _____

Address: _____ City _____ State _____ Zip _____

Home Tel: (____) _____ Cell : (_____) _____ Email: _____

PARENTS INFO (If patient is a minor, please complete.)

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____
_____ _____
_____ _____

Occupation: _____ Occupation: _____

Contact Tel no. (____) _____ Contact Tel no. (____) _____

EMERGENCY CONTACT (Other than the Parent)

Name: _____ Relation to Patient: _____

Contact Tel no. (____) _____

PATIENT INFO

Diagnosis: _____ Date of Diagnosis: _____
_____
_____

Medications: _____
_____
_____

Allergies: Foods: _____
Medications: _____
Environmental: _____
Chemical: _____
Others: _____

Primary Care Physician: _____ Tel No. (____) _____

Address: _____

35 Jolley Drive Suite 102 Bloomfield, CT 06002 U.S.A.
Tel (860)242-2200 Fax (860)242-2200
www.advbiomedtx.com

PATIENT MEDICAL HISTORY

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? YES NO
If YES, please explain. _____
_____

Are you pregnant or think you may be pregnant? YES NO If YES, how many weeks? _____
Are you taking any medications? YES NO If YES, what are you taking?_____
_____
_____

Do you have or have you had any of the following?

AIDS or HIV	YES	NO	Lung Disease	YES	NO
Anemia	YES	NO	Mitral Valve Prolapse	YES	NO
Angina	YES	NO	Neurological Disease	YES	NO
Arthritis	YES	NO	Radiation Therapy	YES	NO
Asthma	YES	NO	Recent Weight Loss	YES	NO
Bronchitis	YES	NO	Seizure Disorders	YES	NO
Cancer	YES	NO	Stomach Problems	YES	NO
Cardiac Pacemaker	YES	NO	Stroke	YES	NO
Chest Pains	YES	NO	Swollen Ankles	YES	NO
Claustrophobia	YES	NO	Thoracic/Ear Surgery	YES	NO
Chronic Cough	YES	NO	Thyroid Problem	YES	NO
Diabetes	YES	NO	Tuberculosis	YES	NO
Emphysema	YES	NO	Other/s: _____		
Epilepsy/Convulsions	YES	NO	_____		
Fainting/Seizures	YES	NO	_____		
Glaucoma	YES	NO			
Hay Fever/Allergies	YES	NO			
Hepatitis/Jaundice	YES	NO			
Heart Attack	YES	NO			
Herpes	YES	NO			
High Blood Pressure	YES	NO			
Infections, Frequent	YES	NO			
Joint Replacement	YES	NO			
Kidney Disease	YES	NO			
Leukemia	YES	NO			
Liver Disease	YES	NO			

Have you ever had any ear problems? YES NO
Do you have any problems with your ears when you fly? YES NO
Notes or Comments: _____
_____
_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of Patient (Parent or Guardian) Date