New healthcare mandates require all Patient Registration information fields be completed.

PATIENT REGISTRATION

FIRST NAME: **LAST NAME:**

(As it appears on your insurance card)

STREET ADDRESS: **ZIP CODE:** **CITY:** **STATE:**

HOME PHONE: **WORK PHONE:** **CELL PHONE:**

(Please put a 1 next to your first preference for calls)

PHARMACY NAMES & ADDRESS: **PHARMACY PHONE:**

COPAY AMOUNT: **EMAIL ADDRESS:** **HOW MANY INSURANCE PLANS?**

SEX: ( ) Male ( ) Female **DATE OF BIRTH:**

REFERRING DOCTOR: **PRIMARY CARE DOCTOR:**

RACE (check one):
( ) White **( ) Black/African American** **( ) American Indian/Alaska Native** **( ) Asian**
( ) Native Hawaiian/Other Pacific Islander **( ) Other** **( )Patient Declined/Unknown**

ETHNICITY:
( ) Spanish/Hispanic Origin
( ) Not of Hispanic Origin
( ) Patient Declined/Unknown

PRIMARY LANGUAGE: **COUNTRY:**

SECONDARY LANGUAGE: **COUNTRY:**

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: **INSURANCE P.O. BOX ADDRESS:**

NAME OF INSURANCE POLICY HOLDER (IF OTHER THAN SELF):	**INSURED'S DATE OF BIRTH:**	**INSURED'S SEX:**
INSURED'S POLICY #:	**RELATIONSHIP TO INSURED:**	

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME: **INSURANCE P.O. BOX ADDRESS:**

NAME OF INSURANCE POLICY HOLDER IF OTHER THAN SELF:	**INSURED'S DATE OF BIRTH:**	**INSURED'S SEX:**
INSURED'S POLICY #:	**RELATIONSHIP TO INSURED:**	

PATIENT NAME: _____ **DATE OF BIRTH:** _____

HEALTH HISTORY

HEALTH MAINTENANCE (check all that apply)					
	Colonoscopy; Reason:	Date:		Endoscopy; Reason:	Date:

MEDICAL PROBLEMS (check all that apply)							
	Abdominal Pain		Constipation		Heart Disease		Kidney problems
	Anemia		Crohn's disease or Colitis		Heartburn/reflux		Nausea/ Vomiting
	Asthma or Lung Disease		Diabetes		Hepatitis		Polyps
	Bleeding problems		Diarrhea		High Blood Pressure		Ulcers
	Cancer , type:		Gastrointestinal Bleeding		Irritable Bowel Syndrome		Other:

SURGERIES		HOSPITALIZATIONS	
Surgery	Date	Reason for Hospitalization	Date

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (** include any vitamins/supplements as well):			
Drug Name	**Dosage**	**Drug Name**	**Dosage**
Do you take any of the following medications?	**Coumadin/Warfarin**	**Plavix**	**Aspirin** **NSAIDs/arthritis pain medicines**

DRUG ALLERGIES	OTHER/SEASONAL ALLERGIES

SOCIAL/PERSONAL HISTORY (Check where applicable)											
Marital status? :		Married		Divorced		Widowed		Single		Domestic Partner	
Are you working?:		No		Yes; Occupation?							
Do you smoke?		No		Yes; What and How much?:							
Did you quit smoking?		No		Yes; How long ago?:							
Do you drink alcohol?		No		Yes; How much?:							
Do you use recreational drugs?		No		Yes; How much?:							

FAMILY HISTORY				
Relative	**Illnesses**	**Deceased**	**Due To**	**Age Deceased**
Father:				
Mother:				
Brother(s):				
Sister(s):				
Other Relatives (who?):				

NAME (PRINT): _____

PRIVACY INFORMATION

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

Can we leave APPOINTMENT information on?

	Yes
Home phone (Include Auto Call)?	
Mobile Phone (Include Auto Call)?	
Mobile Text (Include Auto Call)?	
Work phone	
With Another Person?	
Send via Mail?	
Send via E-mail?	

Can we leave MEDICAL information on?

	Yes
Home Phone (Include Auto Call)?	
Mobile Phone (Include Auto Call)?	
Mobile Text (Include Auto Call)?	
Work Phone?	
With Another Person?	
Send via Mail?	
Send via E-mail?	

If you answered YES to allowing us to discuss your appointment and/or medical information WITH ANOTHER PERSON please list their name(s), relationship(s) and phone # below:

Name: **Relationship:** **Phone#:** **Mobile#:**

_____

_____

_____

_____

Additional HIPAA Contact Instructions:

_____

_____

Do we have your permission to obtain your medication history from the pharmacy? Yes No

Please list any other DOCTORS you would like us to send results to:

_____

_____

_____

_____