



PATIENT REGISTRATION & INSURANCE

Please print clearly and provide current information.

PATIENT INFORMATION

Today's Date: _____ Medical Record # (office use): _____

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Date of Birth: _____ Sex assigned at birth: ☐ Female ☐ Male

Street Address: _____

City: _____ State: _____ ZIP: _____

Mobile Phone: _____ Home/Alternate Phone: _____

Email: _____ Social Security: _____

Preferred Language: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Other ☐ Prefer not to answer

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner Student Status: ☐ Full-time ☐ Part-time ☐ Not a student

Employer: _____ Work Status: ☐ Full-time ☐ Part-time ☐ Self-employed Unemployed Retired Disabled

RESPONSIBLE PARTY / LEGAL REPRESENTATIVE (IF APPLICABLE)

Name: _____ Date of Birth: _____

Phone: _____ ☐ Address same as patient Relationship: _____

Address (if different): _____

INSURANCE INFORMATION

Coverage type: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Workers' Comp ☐ Self-pay ☐ Other

PRIMARY INSURANCE

Insurance Company: _____ Plan Phone: _____ Effective Date: _____

Member ID: _____ Group #: _____

Policyholder Name: _____ Policyholder DOB: _____

Patient relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE (IF APPLICABLE)

Insurance Company: _____ Plan Phone: _____ Effective Date: _____

Member ID: _____ Group #: _____

Policyholder Name: _____ Policyholder DOB: _____

Patient relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

REFERRAL & CARE CONTACTS

Referring Clinician: _____ Phone Number: _____

Primary Care Clinician: _____ Phone Number: _____

How did you hear about us? _____

Please provide: ☐ Photo ID ☐ Primary insurance card (front/back) ☐ Secondary card (if applicable)



PHARMACY NAME:

Phone Number:

Pharmacy Address: _____

PAST MEDICAL HISTORY Check each category that applies. Circle or identify the specific condition(s) you have.

- ☐ **Heart/Cardiac:** atrial fibrillation/arrhythmia, heart failure, coronary artery disease, heart attack, high blood pressure, clotting/DVT
- ☐ **Endocrine/Metabolic:** diabetes, diabetic neuropathy, high cholesterol, hyperthyroid, hypothyroid, obesity
- ☐ **Musculoskeletal:** arthritis/osteoarthritis, fibromyalgia, gout, muscular dystrophy, osteoporosis, rheumatoid arthritis
- ☐ **Gastrointestinal:** gastric ulcer, GERD/heartburn/acid reflux, inflammatory bowel disease
- ☐ **Infectious/Immune/Skin:** HSV, shingles, hepatitis A/B/C, HIV/AIDS, impaired immunity
- ☐ **Kidney/Urinary:** chronic kidney disease, kidney stones
- ☐ **Respiratory:** asthma, COPD/chronic bronchitis, pulmonary hypertension, sleep apnea
- ☐ **Neurologic:** migraine, multiple sclerosis, peripheral neuropathy, Parkinson disease, seizure, stroke/TIA
- ☐ **Psychiatric:** anxiety disorder, bipolar disorder, major depressive disorder, obsessive compulsive disorder, schizophrenia
- ☐ **Hematologic:** anemia, bleeding disorder, blood clotting disorder
- ☐ **Cancer or other medical condition:** _____

SOCIAL HISTORY

Tobacco / vaping: ☐ Never ☐ Current ☐ Former Amount / Quit year: _____ Alcohol: ☐ None ☐ Rare ☐ Weekly ☐ Daily

Cannabis, recreational, or non-prescribed drug use (current or past) ☐ No ☐ Yes Describe: _____

Pregnant, nursing, or could be pregnant? ☐ No ☐ Yes Prior treatment for alcohol or substance use? ☐ No ☐ Yes

Last menstrual period (if applicable): _____ Additional details: _____

FAMILY HISTORY

Check important conditions in parents, siblings, or children and write the relation:

☐ Unknown ☐ Heart Disease _____ ☐ Neurological _____ ☐ Cancer _____

☐ Bleeding/clotting _____ ☐ Anesthesia problems _____ ☐ Kidney Disease _____

Other Condition / Relative / Details: _____

SURGERIES & HOSPITALIZATIONS

Have you had surgery? ☐ No ☐ Yes

Have you had a major hospitalization? ☐ No ☐ Yes

Surgery / Procedure / Hospital	Body Area	Year