



PATIENT REGISTRATION INFORMATION
PLEASE PRINT AND COMPLETE ALL SECTIONS OF THIS FORM

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ SEX M F SOCIAL SECURITY _____

MARITAL STATUS S M W D Other _____ SPOUSE NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ EMAIL ADDRESS _____

PRIMARY CARE PROVIDER _____

RACE White Black Asian Native Hawaiian/Pacific Islander American Indian/Alaskan Native Hispanic Other

ETHNICITY Hispanic/Latino Non-Hispanic/Latino Unreported/Refused

LANGUAGE English Spanish French Arabic Chinese Sign Language

EMPLOYER _____ WORK PHONE _____

Responsible Party Information (for patients under 18 and other dependent patients)

Name: _____ Relationship to patient: _____
Last First Middle Initial

Social Sec. #: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Sex: F M Phone: _____ Home Cell Other
MM/DD/YYYY

Emergency Contact

Name: _____ Phone: _____ Relationship to patient: _____

<p>Patient's Insurance Information</p> <p>Primary Policy: _____</p> <p>Policy Holder: _____</p> <p>Date of Birth: _____</p> <p>Relationship to Patient: _____</p>	<p>Secondary Policy: _____</p> <p>Policy Holder: _____</p> <p>Date of Birth: _____</p> <p>Relationship to Patient: _____</p>
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Patient Registration Form (Continued)

Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Patient Central. I authorize this healthcare provider to release any information necessary to ensure payment by my insurance company. I understand I am financially responsible for all charges not covered by insurance, including patient co-pay, deductible, non-covered services or vaccinations. Charges for paperwork are not covered by insurance, and will be charged a \$30 fee. **I understand that my account may be turned over to collections for failure to make payments within 90 days upon receiving my statement.**



Signature of Patient or Legal Guardian

Date

Acknowledgment of Notice of Privacy Practices

The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy is available to you upon request.



Signature of Patient or Legal Guardian

Date

Notice of Narcotic Policy

I understand that Patient Central does not prescribe narcotic medications. In the event I should need this type of medication, I understand I will be referred to a specialist or pain management clinic. Patient Central does not prescribe long term pain medications. I fully accept and will comply with this policy of Patient Central.



Signature of Patient or Legal Guardian

Date

Missed Appointments / Same Day Cancellation Policy

I also acknowledge I am responsible for payment of the fees listed below relating to missed appointments and same-day cancellations. For every no-show or late cancellation of an office visit or testing without a minimum of 24-hour advance notice, there will be a \$30 charge. More than 3 no shows and/or late cancellation can result in the termination of your care from our practice.

By signing below, I agree to the above communication preferences, privacy practices, as well as assignment of benefits.



Signature of Patient or Legal Guardian

Date

Patient Name: _____ DOB: _____ Date: _____
MM/DD/YYYY

Reason for being seen today: _____

Have you had any recent international travel? Yes No

Is this a follow up visit? Yes No

Do you need medication refills? Yes No

Allergies:

Are you allergic to any medications? Yes No
If Yes, please list all.

Do you have any other allergies? Yes No
If Yes, please list all.

Medications:

Are you taking any medications, prescription or over the counter, right now? Yes No
If Yes, please list all medications.

Medication Name	Strength	Quantity taken at one time	Times per day taken

Please list any other medications on the back of this form.

Social History:

Do you use tobacco?	<input type="checkbox"/> Yes, everyday	<input type="checkbox"/> Yes, on occasion	<input type="checkbox"/> No, former user	<input type="checkbox"/> No, never
Do you drink alcohol?	<input type="checkbox"/> Yes, everyday	<input type="checkbox"/> Yes, socially	<input type="checkbox"/> No, former user	<input type="checkbox"/> No, never
Do you use illegal drugs?	<input type="checkbox"/> Yes, everyday	<input type="checkbox"/> Yes, socially	<input type="checkbox"/> No, former user	<input type="checkbox"/> No, never
Are you currently employed?	<input type="checkbox"/> Yes, full time	<input type="checkbox"/> Yes, part time	<input type="checkbox"/> No, retired	<input type="checkbox"/> No, other

Family History:

Does any of your immediate blood relatives (grandparents, parents, siblings) have any of the following conditions?

Condition	Yes	No	Relative	Condition	Yes	No	Relative
Diabetes				Osteoarthritis			
High Blood Pressure				Rheumatoid Arthritis			
Heart Disease				Heart Attack/ Murmurs			
Cancer				Thyroid Disease			
Type				High Cholesterol			
Kidney Disease				Liver Disease			
Dementia				Stroke			

Date: _____ Name: _____ Birthdate: _____

Medical History

Do you have any current medical conditions you are being treated for? yes no Please list.

Do you have any past medical conditions you have been treated for? yes no Please list.

Surgical History

Have you ever had any surgeries? yes no Please list and specify Right or Left if applicable. (May add additional information on back of form)

Hospitalization History

Have you ever been hospitalized overnight? yes no Please list when and where as well as reason. (May add additional information on back of form)

<p>General:</p> <input type="checkbox"/> Good Health Lately <input type="checkbox"/> Recent unexplained weight loss or gain <input type="checkbox"/> Fever/Chills/Sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches <p style="text-align: right;">When: _____</p>	<p>Eyes:</p> <input type="checkbox"/> Eye disease or injury <input type="checkbox"/> Wear glasses or contacts <input type="checkbox"/> Blurred Vision/Glaucoma/Cataracts <input type="checkbox"/> Flashing Lights/Floaters <input type="checkbox"/> Watery/Itchy/Discharge from eyes <p style="text-align: right;">When: _____</p>
<p>Ears, Nose, Throat, Mouth</p> <input type="checkbox"/> Hearing loss or ringing <input type="checkbox"/> Earache or drainage <input type="checkbox"/> Chronic sinus problems/head congestion <input type="checkbox"/> Swollen glands in neck <input type="checkbox"/> Sore throat or voice changes <input type="checkbox"/> Environmental Allergies <p style="text-align: right;">When: _____</p>	<p>Cardiovascular:</p> <input type="checkbox"/> Heart Problems <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Swelling of ankles/hands/feet <input type="checkbox"/> Passing out spells <p style="text-align: right;">When: _____</p>
<p>Respiratory</p> <input type="checkbox"/> Chronic or frequent coughs <input type="checkbox"/> Spitting/coughing up blood <input type="checkbox"/> Asthma or wheezing <input type="checkbox"/> Shortness of breath <p style="text-align: right;">When: _____</p>	<p>Gastrointestinal</p> <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea/Vomiting/Diarrhea/Constipation <input type="checkbox"/> Change in Bowel Movements <p style="text-align: right;">When: _____</p>
<p>Musculoskeletal</p> <input type="checkbox"/> Joint pain/stiffness/swelling/warmth <input type="checkbox"/> Weakness of muscles or joints <input type="checkbox"/> Muscle pain or cramps <input type="checkbox"/> Back pain <input type="checkbox"/> Difficulty walking <p style="text-align: right;">When: _____</p>	<p>Skin</p> <input type="checkbox"/> Rash or itching <input type="checkbox"/> Sunburns as a child <input type="checkbox"/> Change in skin color/moles <input type="checkbox"/> Change in hair or nails <input type="checkbox"/> Varicose Veins <p style="text-align: right;">When: _____</p>
<p>Neurological</p> <input type="checkbox"/> Light headed or dizziness <input type="checkbox"/> Convulsions or seizures <input type="checkbox"/> Numbness or tingling sensations <input type="checkbox"/> Tremors <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Head Injury <p style="text-align: right;">When: _____</p>	<p>Psychiatric</p> <input type="checkbox"/> Memory Loss or confusion <input type="checkbox"/> Difficulty with anger <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Trouble Sleeping <input type="checkbox"/> Hospitalized for emotional problems <p style="text-align: right;">When: _____</p>
<p>Endocrine</p> <input type="checkbox"/> Gland or hormonal problems <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Problems with blood sugar/diabetes <input type="checkbox"/> Frequent Thirst for no reason <input type="checkbox"/> Heat or cold intolerance <p style="text-align: right;">When: _____</p>	<p>Hematologic/Lymphatic</p> <input type="checkbox"/> Slow healing cuts or bruises <input type="checkbox"/> Anemia <input type="checkbox"/> Past blood transfusions <input type="checkbox"/> Enlarged lymph nodes in groin/armpits <input type="checkbox"/> Easier bruising than usual for you <p style="text-align: right;">When: _____</p>
<p>FOR WOMEN:</p> <p>Genitourinary</p> <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Burning/Painful Urination <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> History of kidney infections/stones <input type="checkbox"/> Blood in urine <input type="checkbox"/> Vaginal discharge/odor/itching <input type="checkbox"/> Pain during sex <input type="checkbox"/> Lack of sexual desire <input type="checkbox"/> Painful/heavy periods <input type="checkbox"/> PMS or Menopausal symptoms <p style="text-align: right;">When: _____</p>	<p>FOR MEN:</p> <p>Genitourinary</p> <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Burning/Painful Urination <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> History of kidney infections/stones <input type="checkbox"/> Blood in urine <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Testicular pain <input type="checkbox"/> Lack of sexual desire <input type="checkbox"/> Discharge from penis <input type="checkbox"/> Pain during sex <p style="text-align: right;">When: _____</p>

Protected Health Information Patient Preferences

Please help us accommodate your wishes regarding how we communicate with you about your health care by completing and signing this form.

Yes No May we use your first name, last name, or both to identify you in the waiting room? If not, how would you prefer to be identified?

Yes No May we leave a message on your answering machine or voicemail reminding you of an appointment, or requesting that you call our office? If not, is there an alternate method of contacting you by phone?

Portal Cell Other

Yes No May we leave information regarding an upcoming appointment or a request for you to call us with another individual in your household?

Yes No May we send written correspondence in a sealed envelope to your home address? If not, is there an alternative address where we may send confidential communications to?

Yes No Is there another person with whom you give permission for us to speak with about your health care? If yes, please list name(s) and relationship.

Please list any physicians you would like copies of office notes and test results sent to.



Signature of Patient or Legal Guardian

Date

**Thank you for choosing Patient Central.
We look forward to caring for you!**

Are You At Risk of **HEART ATTACK?**

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Have you recently experienced any of the following symptoms?

- | | |
|---|---|
| <input type="checkbox"/> Chest Pain / Pressure / Aching | <input type="checkbox"/> Heart Burn |
| <input type="checkbox"/> Neck or Jaw Tightness | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Racing or Skip Beats | <input type="checkbox"/> Unusual Sweating |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Leg Heaviness or Cramping | <input type="checkbox"/> Leg Swelling |
| <input type="checkbox"/> Persistent Sores on Legs | <input type="checkbox"/> Unusual Fatigue/Weakness |

Do you have any of the following conditions?

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Smoking History |
| <input type="checkbox"/> Family History of Heart Disease | <input type="checkbox"/> PAD (Peripheral Arterial Disease) |
| <input type="checkbox"/> Heart Murmur or Heart Valve Problem | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Known Heart Disease | <input type="checkbox"/> Stroke History |

Prevent Heart Disease!
www.samedayheartcare.com