REGISTRATION & HISTORY FORM

Date _____

PATIENT INFORMATION

_____
First Name Middle Initial Last Name

Address_____

_____
City State Zip

Social Security Number_____

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer _____

Occupation/position _____

Who referred you ? _____

PHONE NUMBERS

Home (_____) _____

Cellular (_____) _____

Work (_____) _____

EMERGENCY CONTACT PERSON:

Name _____

Relationship _____

Home (_____) _____

Cellular (_____) _____

Work (_____) _____

INSURANCE CARDHOLDERS INFO.

Name _____

Birthdate _____

Social Security Number _____

Relationship to patient _____

Insurance coverage: Please provide names of insurance(s)

Primary insurance _____

Secondary insurance _____

Third insurance _____

PHYSICIAN INFO.

Family Doctor _____

Date last seen _____

PHARMACY INFO.

Name _____

Location _____

Phone _____

RESPONSIBLE PARTY INFO. IF PATIENT IS A MINOR (UNDER AGE 18)

Name _____ Relationship to minor _____

Address _____

Phone _____

OFFICE USE:

Referring Doctor/Source: _____

MEDICAL HISTORY Name _____ Date _____ Chart # _____

Height _____ Weight _____ Shoe size _____

Cigarette/Tobacco use ? ☐ Yes ☐ No Years smoked/used _____ packs/day _____

Are you a diabetic ? ☐ Yes ☐ No If yes, for how long _____ and do you take insulin ? ☐ Yes ☐ No

If diabetic, when and what was your latest blood sugar reading ? When ? _____ Reading ? _____

Please **circle** the conditions listed below to indicate if you currently have or have had any of the following:

AIDS/HIV	Chemical dependency	Headaches	Psychiatric care
Anemia	Chronic diarrhea	Heart disease	Respiratory disease
Angina (chest pain)	Circulation problems	Hemophilia	Rheumatic fever
Arthritis	Ear problems	Hepatitis or jaundice	Stroke
Artificial heart valves	Epilepsy	High blood pressure	Swelling of legs
Artificial joints	Eye problems	Kidney problems	Tuberculosis
Asthma	Fainting	Liver disease	Ulcers of skin
Back problems	Foot or leg cramps	Low blood pressure	Ulcers of stomach
Bleeding disorders	Fibromyalgia	Neuropathy	Varicose vein
Cancer	Gout	Phlebitis	Venereal disease

Any unexplained weight loss ? _____ If yes, explain _____

Other conditions(s) _____

SURGERIES _____

_____

MEDICATIONS _____

_____

_____

☐ Check here if you take prescriptions but do not know the names and did not bring the medicines or a listing of them
☐ Check here if you provided our office with a list of your medications

ALLERGIES

☐ Adhesive/Tape	☐ Demerol	☐ Novacaine	☐ NONE
☐ Anticoagulation therapy	☐ Iodine	☐ Penicillin	
☐ Aspirin	☐ Latex	☐ Seafoods	
☐ Codeine	☐ Local anesthetic	☐ Sulfa drugs	

Other _____