Patient Registration

## Patient Information

| First Name | Last Name | MI | Date of Birth |
|---|---|---|---|
| Address | City | State | Zip |

| Please check Primary phone | Home Phone ☐ | Work Phone ☐ | Cell Phone ☐ |
|---|---|---|---|

| Other Name(s) Used | E-mail Address |
|---|---|

| Gender ☐ M ☐ F | SSN | Preferred Language | Driver's License |
|---|---|---|---|

**Marital Status**
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Life Partner

**Preferred Contact**
- ☐ Home Phone
- ☐ Work Phone
- ☐ Cell Phone

**Ethnicity**
- ☐ Non-Hispanic
- ☐ Hispanic

**Race**
- ☐ White
- ☐ African American
- ☐ Asian
- ☐ Other

| Previous Primary Care Doctor | How did you hear about us ? |
|---|---|

## Responsible Party (Guarantor) ☐ Same as patient

| First Name | Last Name | MI | Date of Birth |
|---|---|---|---|
| Address | City | State | Zip |

| Please check Primary Phone | Home Phone ☐ | Work Phone ☐ | Cell Phone ☐ |
|---|---|---|---|

| SSN | Relationship to Patient | Preferred Language | Driver's License |
|---|---|---|---|

## Emergency Contact (for minor child, this section may be used for other parent)

| First Name | Last Name | MI | Date of Birth |
|---|---|---|---|
| Address | City | State | Zip |

| Please check Primary Phone | Home Phone ☐ | Work Phone ☐ | Cell Phone ☐ |
|---|---|---|---|

I do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the Your Choice Primary Care to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, and I authorize my insurance company to make payments directly to Your Choice Primary Care for covered medical and/or surgical services. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Your Choice Primary Care to release information requested by insurance company and/or its representatives, and by other physicians and staff who participate in my care. I fully understand this agreement and consent will remain in effect until cancelled by me in writing.

Signature of Patient/Responsible Party _____ Date _____

Name of Patient/Responsible Party _____ Relationship to Patient _____

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| Pharmacy Information | |
|---|---|
| Preferred Pharmacy | Secondary Pharmacy |
| Name | Name |
| Address | Address |
| Phone | Phone |

**Advanced Directives**

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed:

**Medications – List all Medications you take, prescription and non-prescription, and the Dosage and Frequency**

☐ I do not take any medications

| Medication Name | Dosage and Frequency |
|---|---|
| | |
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| | |

**Medication Allergies – List all known Allergies and the Reactions**

☐ No Known Allergies

| | |
|---|---|
| | |
| | |

**Medical History – Check if you have ever experienced the following conditions, and the year of onset**

| Condition | Year | Condition | Year |
|---|---|---|---|
| ☐ None | | ☐ GERD / Acid Reflux | |
| ☐ Acne | | ☐ Gout | |
| ☐ Allergy | | ☐ Hyperlipidemia / High Cholesterol | |
| ☐ Anemia | | ☐ Hypertension / High Blood Pressure | |
| ☐ Anxiety | | ☐ Irritable Bowel Syndrome | |
| ☐ Arthritis | | ☐ Kidney Disease | |
| ☐ Asthma | | ☐ Liver Disease | |
| ☐ Atrial Fibrillation | | ☐ Lupus | |
| ☐ Blood Clots / Deep Vein Thrombosis | | ☐ Migraine | |
| ☐ Cancer – Type | | ☐ Osteoporosis | |
| ☐ Cerebrovascular Accident / Stroke | | ☐ Peptic Ulcer Disease | |
| ☐ Coronary Artery Disease | | ☐ Psoriasis | |
| ☐ Congestive Heart Failure | | ☐ Rheumatoid Arthritis | |
| ☐ COPD / Emphysema | | ☐ Seizure Disorder | |
| ☐ Depression | | ☐ Sexually Transmitted Disease | |
| ☐ Diabetes Mellitus | | ☐ Thyroid Disease | |
| ☐ Enlarged Prostate / BPH | | ☐ Tuberculosis / TB | |
| ☐ Erectile dysfunction | | ☐ Other | |
| ☐ Gallbladder Disease | | ☐ Other | |

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| Surgical History – Check if you have received any of the following procedures, and the year it was performed | | | |
|---|---|---|---|
| Surgical Procedure | Year | Surgical Procedures | Year |
| ☐ None | | Male Only | |
| ☐ Angioplasty | | ☐ Circumcision | |
| ☐ Angioplasty with Stent | | ☐ Prostate Surgery | |
| ☐ Appendectomy | | ☐ Vasectomy | |
| ☐ Arthroscopy | | Female Only | |
| ☐ Back Surgery | | ☐ Breast Augmentation | |
| ☐ CABG / Coronary Bypass Surgery | | ☐ Breast Reduction | |
| ☐ Carpal Tunnel | | ☐ Breast Cancer Surgery | |
| ☐ Cataract | | ☐ Cesarean Section | |
| ☐ Cholecystectomy | | ☐ D and C / Abortion | |
| ☐ Colectomy | | ☐ Hysterectomy | |
| ☐ Colostomy, Ileostomy, Feeding Tube | | ☐ Hysterectomy, Ovaries removed | |
| ☐ Gastric Bypass, Sleeve, Lap Band | | ☐ Myomectomy | |
| ☐ Hernia Repair | | ☐ Tubal Ligation | |
| ☐ Hip Replacement | | | |
| ☐ Knee Replacement | | ☐ Other | |
| ☐ LASIK | | ☐ Other | |
| ☐ Liver Biopsy | | ☐ Other | |
| ☐ Nephrectomy /Kidney Surgery | | ☐ Other | |
| ☐ Pacemaker, Defibrillator | | ☐ Other | |
| ☐ Thyroidectomy / Thyroid Surgery | | ☐ Other | |
| ☐ Tonsillectomy | | ☐ Other | |

| Health Maintenance – Check if you have received any of the following, and date of most recent exam | | | |
|---|---|---|---|
| Exam | Date | Exam | Date |
| ☐ Routine Physical, Blood Work | | ☐ FOBT / stool blood test | |
| ☐ Chest Xray | | ☐ Bone Density Scan | |
| ☐ EKG / Electrocardiogram | | ☐ Abdominal Aortic Aneurism / AAA | |
| ☐ Cardiac Stress Test | | ☐ Skin Mole Check / Biopsy | |
| ☐ Prostate Exam / PSA | | ☐ STD check | |
| ☐ Male Hormone / Testosterone | | ☐ Eye Exam for Glaucoma, Cataracts | |
| ☐ Pap Smear | | ☐ Influenza Vaccine | |
| ☐ Mammogram | | ☐ Pneumococcal Vaccine | |
| ☐ Colonoscopy | | ☐ Tetanus Vaccine | |
| ☐ Sigmoidoscopy | | ☐ Shingles Vaccine | |

Family History – Check if any Family member(s) has had any of the following conditions

☐ Adopted

| Diagnosis | Mother | Father | Grand M | Grand F | Siblings | Children | Other |
|---|---|---|---|---|---|---|---|
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alzheimer's Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Blood Clots / Deep Vein Thrombosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Blood Diease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| CAD / Heart Attack | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| CVA / Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes Mellitus | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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## Family History – continued

| Diagnosis | Mother | Father | Grand M | Grand F | Siblings | Children | Other |
|---|---|---|---|---|---|---|---|
| Hyperlipidemia / High Cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hypertension / High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hyperlipidemia (High Cholesterol) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Liver Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lupus | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Obesity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoarthritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Social History

| | | | |
|---|---|---|---|
| Occupation | | Employer | |
| Do you have children? ☐ Yes ☐ No | How many? | Female(s) | Male(s) |
| Tobacco Use<br>☐ No | ☐ Daily ☐ Weekly ☐ Rarely<br>☐ Former/Year quit: | ☐ Chewing ☐ Pipe<br>☐ Cigar ☐ Cigarette<br>☐ Smokeless | |
| Alcohol Use<br>☐ No | ☐ Daily ☐ Weekly ☐ Rarely<br>☐ Former/Year quit: | ☐ Beer ☐ Wine<br>☐ Liquor ☐ Other | |
| Exercise Activity | ☐ <30mins ☐ 30-60mins ☐ >60mins<br>Days/Week: | Type of Exercise | |
| Caffeine Use<br>☐ No | ☐ Daily ☐ Weekly ☐ Rarely<br>☐ Former/Year quit: | ☐ Chocolate ☐ Coffee<br>☐ Soda ☐ Tea<br>☐ Energy Drinks ☐ Other | |

## Social History for Children

| | | | | | |
|---|---|---|---|---|---|
| Patient Reside with: | Primary | ☐ Mother | ☐ Father | ☐ Both Parents | ☐ Other: |
| | Secondary | ☐ Mother | ☐ Father | ☐ Other: | |
| Mother's Occupation | | | Father's Occupation | | |
| Parents Relationship<br>☐ Married ☐ Single<br>☐ Divorced ☐ Separated<br>☐ Widowed | | | Childcare<br>☐ Mother ☐ Grandparent<br>☐ Father ☐ Nanny<br>☐ Sibling ☐ Daycare | | |
| Tobacco Exposure: ☐ Yes ☐ No<br>Smokers at home: ☐ Yes ☐ No | | | Patient is current smoker? ☐ Yes ☐ No | | |

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