(PLEASEPRINT) **PATIENT REGISTRATION FORM**

For Office Use Only
Dr #_____

Patient Name : _____
(Last) (First) (MI) Sex ☐M ☐F

Date of Birth : _____ SS# _____ Age : _____

Marital Status ☐Single ☐Married ☐Divorced ☐ Separated
:

Patient Address _____
Street, Apt.# (City, State) (Zip)

Patient Phone No. (Incl. Area Code): (H) _____ (W) _____ (M) _____

Sexual Preference ☐ Heterosexual ☐ Bisexual ☐ Asexual ☐ Homosexual

INSURANCE INFORMATION

Primary Insurance

Name of Insurance Co: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Subscriber's SS# _____ Sex _____ Employer of Subscriber : _____

Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Policy Effective Date: _____ Policy # _____ Group # _____

Secondary Insurance

Name of Insurance Co: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Subscriber's SS# _____ Sex _____ Employer of Subscriber : _____

Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Policy Effective Date: _____ Policy # _____ Group # _____

Employer: _____

Occupation: _____

Address: _____

Phone #: _____

Social History

Cigarette Use ☐ Never ☐ Currently ☐ Past

If in the past how long ago did you quit? _____

If currently, how many cigarettes per day? _____

Alcoholic Beverages ☐ Never ☐ Rarely ☐ Socially ☐ Daily

If in the past, how long ago did you stop? _____

If socially, how often do you have a drink? _____

Recreational drug use ☐ Never ☐ Currently ☐ Socially ☐ Past

What type of drugs do/did you use? _____

How often do/did you use these substances? _____

Do you exercise? ☐ Yes ☐ No ☐ Sometimes

If so, what do you do and how long? _____

How many days per week? _____

Medical Conditions

1._____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

Surgical History

1._____ 4. _____ 7. _____

2. _____ 5. _____ 8._____

3. _____ 6. _____ 9. _____

Current Medications

1._____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

Allergies: _____

Pharmacy Name:

_____

Pharmacy Address:

_____

Pharmacy Phone # (Incl. Area Code):

_____

Pharmacy Fax # (Incl. Area Code):

_____

Other Physicians (please include specialty and phone number)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

Emergency Information

Name: _____

Emergency Contact Phone# (Incl. Area Code):

(H)_____ (W)_____ (M)_____

Additional Information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____