NEW PATIENT REGISTRATION FORM

Please print the following information

PERSONAL INFORMATION

Date Today: .....

Name ..... Birth Date ..... Sex .....
First M.I. Last

Address .....
Street Address P.O. Box/Apt# City State Zip Country

Marital Status..... Race ..... Education..... Email.....

Phone: (Home) .....(Work)..... (Cell) .....

Closest Relative (include address).....

.....

Relative Phone:..... Spouse/Sig. Other ..... Referred by.....

Employer ..... Occupation.....

Medications/Herbs/HomeRemedies.....

.....

Allergies (including medication).....

Diet (please describe)- Breakfast .....

Lunch.....

Dinner.....

Exercise (please describe) .....

INSURANCE INFORMATION: Please fill out the following information for the holder of the insurance policy or legal gaurdian

Insurance Co.. ..... Group #..... Policy # .....

Insured Name ..... Birth Date ..... Sex .....
First M.I. Last

HOSPITALIZATIONS: YEAR OPERATION/ILLNESS NAME OF HOSPITAL CITY AND STATE

First.....

Second .....

Third .....

Fourth .....

CHIEF COMPLAINT

Reason for this visit .....

Was there an initiating event? .....

What was different within 6 months before the onset of the problem.....

.....

MEDICAL HISTORY

☑ **CHECK** every condition that you have *ever had.*

☑ **CIRCLE** conditions currently present.

☑ **WRITE** the **age of onset.** 7 y/o

EYES
- ☐ Failing vision
- ☐ Double or blurred vision
- ☐ Squinting/"crossed" eyes/
- ☐ Asymmetric gaze
- ☐ Eye pain
- ☐ Eye infections
- ☐ Lose place when reading
- ☐ Poor reading comprehension
- ☐ Eyestrain or fatigue from reading
- ☐ Headache from reading
- ☐ Glasses or contacts
- ☐ Monovision/Progressive lenses

ENT
- ☐ Decreased hearing
- ☐ Loud voice
- ☐ Snoring/Mouth breathing
- ☐ Ringing/Buzzing in ears
- ☐ Ear infections
- ☐ Allergies/Hay fever/Runny nose
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Frequent sore throats
- ☐ Prolonged hoarseness
- ☐ Speech problems

CARD-PULM
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Shortness of breath on exertion
- ☐ Shortness of breath on lying flat
- ☐ Chest pains
- ☐ Heart murmurs
- ☐ Palpitations
- ☐ Swollen ankles
- ☐ Fainting spells
- ☐ Leg pain when walking
- ☐ Varicose veins/Phlebitis

GI
- ☐ Eating disorder
- ☐ Recent loss of appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Persistent nausea/vomiting
- ☐ Ulcers
- ☐ Chronic abdominal pain
- ☐ Recent change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black or tarry stools
- ☐ Red blood in stools
- ☐ Hemorrhoids
- ☐ Diverticulosis
- ☐ Gall bladder trouble
- ☐ Jaundice/Hepatitis
- ☐ Hernia

ENDO
- ☐ Chronic fatigue
- ☐ Recent weight loss
- ☐ Excessive weight gain
- ☐ Thyroid disease
- ☐ Cancer
- ☐ Diabetes

NEURO
- ☐ Convulsions/Seizure
- ☐ Stroke
- ☐ Tremors
- ☐ Muscle weakness
- ☐ Numbness/Tingling sensation
- ☐ Frequent headaches
- ☐ Clumsiness

MS
- ☐ Joint pain
- ☐ Scoliosis/Kyphosis
- ☐ Arthritis
- ☐ Gout
- ☐ Cold or numb feet
- ☐ Involved in contact sports

DERM
- ☐ Rashes
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hives
- ☐ Unusual moles

PSYCH/EMOTIONAL
- ☐ Difficulty Sleeping
- ☐ Nightmares
- ☐ Nervousness/Anxiety
- ☐ Stress
- ☐ Depression
- ☐ Memory loss
- ☐ Moodiness
- ☐ Phobias
- ☐ Nail biting/thumb sucking
- ☐ Bad temper/breath holding/
- ☐ Jealousy

ILLNESSES
- ☐ Mumps
- ☐ Measles
- ☐ German measles
- ☐ Chicken pox
- ☐ Polio
- ☐ Scarlet fever
- ☐ Rheumatic fever
- ☐ TB
- ☐ Meningitis

HABITS
- ☐ Alcoholism
- ☐ Alcohol .....
- ☐ Cigarette .....packs/day
- ☐ Coffee/Tea .....cups/day

HEME
- ☐ Anemia
- ☐ Malaria
- ☐ Bruise easily/Bleeding
- ☐ Mononucleosis
- ☐ Unexplained lumps
- ☐ Fever/Chills/Excessive sweating

GU
- ☐ Bed wetting
- ☐ Bladder infections
- ☐ Kidney infection
- ☐ Pain on urination
- ☐ Poor control of urination
- ☐ Decreased force of urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Discharge from penis or vagina
- ☐ Sexually transmitted disease

FEMALE ONLY:

Number of pregnancies .....
Number of live births.....
Number of miscarriages .....
Method of birth control.....
Age of onset of menses.....
Flow: ☐ Light ☐ Moderate ☐ Heavy
- ☐ Period Not Regular
- ☐ Length of Flow .....
- ☐ Length of Cycle.....
- ☐ Pain/bleeding with intercourse
- ☐ PMS (medium to severe)

STRESS

Check any of the following that occurred in your family the past year:

☐ Marriage ☐ Births ☐ Serious illness
☐ Divorce ☐ Deaths ☐ Separation
☐ Job loss ☐ Move ☐ Other.....

DENTAL
- ☐ Orthodontic treatment
- ☐ Dental extractions
- ☐ Crowns
- ☐ Root canal work
- ☐ Fillings
- ☐ Bridgework
- ☐ Retainer/Night guard
- ☐ Gum problems

☐ Grind teeth

TRAUMA

List all following with age of occurence

Falls. .....

.....

.....

.....

Bumps. .....

.....

..... Sprains/Strains. .....

.....

.....

.....

.....

Concussions .....

.....

Broken bones .....

.....

Accidents .....

.....

.....

.....

.....

OTHER

.....

.....

.....

PEDIATRIC *(for patients **18 years old and younger only.**)*

PREGNANCY (Mother)

Mothers age when pregnant .....

What number pregnancy was this? .....

Number of abortions/Miscarriages? .....

Number of live births? .....

☐ Unplanned pregnancy

☐ Complications

☐ In vitro

☐ Artificial Insemination

☐ Amniocentesis

Number of ultrasounds .....

Medications during pregnancy:

.....

.....

☐ Trauma during the pregnancy

☐ Illnesses during pregnancy

LABOR

☐ False labor

How long was active labor .....

☐ Difficult labor

☐ Pitocin

☐ Pain medication

☐ Epidural or spinal anesthesia

DELIVERY

When was the baby born relative to the due date? .....

Baby's position .....

☐ C-section

☐ Forceps

☐ Episiotomy

☐ Vacuum extraction

☐ Cord wrapped around the neck

☐ Difficult/traumatic delivery

☐ Meconium staining

NEWBORN

What was the birth weight .....

APGARs: 1 min. .....5 min. .....

☐ Head asymmetrical/uneven at birth

☐ Unusual cry at birth

NUTRITION

☐ Breast

☐ Formula .....

☐ Other .....

☐ Did NOT nurse immediately after birth

☐ Difficulty nursing

INFANT

☐ Spitting up

☐ Rigidly arches backwards

☐ Muscle tone feel loose or floppy

☐ Muscle tone feel too tight or rigid

☐ Torticollis (head and neck side-bent)

☐ Colic

☐ Age of first illness

☐ Helmet use for uneven head

BABY

Age first sleep through night .....

☐ Used a walker or any similar device

☐ Used a swing

☐ Growth and development problems

What age did your child:

Sit up ..... Creep .....

Crawl ..... Cruise .....

Walk ..... Talk .....

SENSITIVITIES

☐ Easily startled?

☐ Food sensitivities

☐ Picky eater

☐ Difficulty wearing certain clothing

MOTOR SKILLS

☐ Clumsiness

☐ Difficulty drawing a straight line, circle, square, complex figure (age appropriate)

SCHOOL

☐ Poor grades in school?

☐ Homework difficult

☐ Poor concentration/short attention span

☐ Doesn't get along with classmates

EXPOSURE/HABITS

☐ Possible lead exposure (old home/plumbing/peeling paint)

☐ Smokers in household

☐ TV – hours per day .....

☐ Computers – hours per day .....

☐ Video games – hours per day .....

☐ Suck finger/thumb/lip/pacifier

☐ Nail biting

Your relationship to child .....

Location of birth .....

Is the child yours by:

☐ Birth ☐ Adoption ☐ Marriage

Other .....

Are both biological parents raising the child ☐ Yes ☐ No

Parents: ☐ Unmarried ☐ Married ☐ Separated ☐ Divorced

Who lives in the home?

.....

.....

Father's professions .....

Mother's professions .....

Is your child:

☐ Irritable ☐ Aggressive ☐ Shy

SIBLINGS

List all siblings

.....

.....

.....

.....

OTHER MEDICAL TREATMENT: List all Physicians from whom you are currently receiving treatment along with the condition(s).

Physican Name	Illness(es)	Treatment Program

FAMILY HISTORY Please look down the list of diseases and *check any listed family member that applies.*

Relative / Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Asthma												
AutoImmune Disorder												
Bleeding Problem												
Cancer												
Congenital Anomaly/Birth defect												
Heart Disease												
Depression												
Diabetes												
Eczema												
Psoriasis												
Food allergy												
Genetic disorder												
Hay Fever												
Hearing disorder												
Kidney disease												
High Cholesterol												
High blood pressure												
Immune disorder												
Mental retardation												
Scoliosis/Kyphosis												
Stroke												
Substance abuse												
Thryroid dusorder												
Tobacco use												
Tuberculosis												
Death before age 56												
Learning disorder												
Other												

IMMUNIZATIONS Please list *any* type of immunization *reaction or adverse effect*.

Immunization	Describe reaction including severity, length of time, and age.
DPT	
Tetanus booster	
Polio	
MMR	
Hib	
Varicella	
Prevnar	
Hepatitis A	
Hepatitis B	
Other	

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used of disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: Initials: Reason: