PATIENT REGISTRATION

PATIENT INFORMATION

First Name_____Last Name_____Middle Initial_____

Home Address_____City_____ State_____Zip_____

Mailing Address_____ City_____ State_____Zip_____

Home Phone_____ Cell Phone_____ DOB_____

Sex □ Male □ Female Marital Status □ Married □ Single □ Widowed □ Divorced □ Separated

Social Security #_____ Occupation_____

Employer_____ Address_____

City_____ State_____ Zip_____ Phone_____

GUARANTOR INFORMATION (Policy Holder)

First Name_____Last Name_____Middle Initial_____

Home Address_____City_____ State_____Zip_____

Mailing Address_____ City_____ State_____Zip_____

Home Phone_____ Cell Phone_____ DOB_____

Social Security #_____ Occupation_____

Employer_____ Address_____

City_____ State_____ Zip_____ Phone_____

Primary Insurance	**Secondary Insurance**
Insurance Name_____	Insurance Name_____
Policy #_____	Policy #_____
Group #_____	Group #_____
Insurance Address_____	Insurance Address_____
Insurance Phone_____	Insurance Phone_____

Do you have a third insurance? □ Yes □ No Insurance Info_____

Emergency Contact

Name_____ Phone_____ Relationship_____

SOCIAL HISTORY

Tobacco Use: □ Never □ Previous Smoker □ Cigarettes □ Cigars How much per day_____

Alcohol Use: □ Never □ Previous Drinker Amount per day/week/month_____

Do you drink caffeine? □ Yes □ No How much per day?_____

Do you use recreational drugs? □ Yes □ No □ Previous User What drug?_____

Do you practice safe sex? □ Yes □ No Do you wear a seat belt? □ Yes □ No

FAMILY HISTORY – Please list the person in your family that has the corresponding conditions

Hypertension_____ Diabetes_____ Allergies_____ Asthma_____ Arthritis_____
Alcoholism_____ Heart Disease_____ Stroke_____ Cancer_____ Seizures_____
Glaucoma_____ Gout_____ Kidney Disease_____ Thyroid Disease_____
Migraines_____ Depression_____ Obesity_____ Anxiety_____

PAST MEDICAL HISTORY – Circle all that apply

Alcoholism, Chest pain, Arthritis, Asthma, Blood disease, Cancer, Fibrocystic Breast, Bronchitis, Tumor, Depression, Diabetes, Emphysema, Epilepsy, Gallstones, German Measles, Glaucoma, Gout, Fibromyalgia, Neck Pain, Back Pain, Heart Attack, Stroke, Hemorrhoids, Hepatitis, Hernias, HIV, High Blood Pressure, Liver Disease/ Cirrhosis, Lung Problem, Kidney Problem, Major Trauma, Migraines, Headaches, Pancreatitis, Pneumonia, Polio, Psychiatric Problems, Rheumatic Fever, Heart Disease, Skin Disease, Sinusitis, Thyroid Disease, Tuberculosis, Ulcers, Urinary Tract Infections, Venereal Disease, Other_____

SURGICAL HISTORY – Type and Year

_____

Do you have allergies to any medications or foods? Please list_____

Do you have a living will or Medical Power of Attorney? □ Yes □ No (copy required for your file)
□ Copy Received □ Copy Requested

I authorize release of any medical information necessary to process Medicare and/or any insurance claims. I authorize payment of medical benefits to Dr Anita Dai, MD. I understand I am responsible for any deductibles, co-payments, co-insurance or amounts not covered by the insurance carrier. I further understand any collection fees will also be my responsibility.

_____ _____
Patient/Guardian Signature Date

MEDICATION LIST

Medication Name	Dosage	Prescribed By