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NEW PATIENT REGISTRATION FORM

Patient Information:

Date: ____________ Name: ____

Date of Birth: ________________ SSN: ______________ Gender: ____________________

Address: ____City: ____________ State: _____ ZIP: __________

Cell Phone: _________________ Home Phone: ____________________ Work Phone: _____________

Email Address: ______________________________________

Occupation: _______________________ Employer: _________________________

Employer Address: ___________________________________ City: ____________ State: _____ ZIP: _______

Emergency Contact: ___________________________________ Relationship: __________________

Address: ____ Phone: ________________________

IF Patient has a Guardian or is a Minor:

Guardian/Caregiver Name: ______________________________ Relationship:______________________

Date of Birth: ________________ SSN: ______________ Gender: ____________________

Address: ____City: ____________ State: _____ ZIP: _______

Cell Phone: _________________ Home Phone: ____________________ Work Phone: _____________

Email Address: ______________________________________

Insurance Information:

Primary Insurance: ________________________________ Subscriber ID: _____________________

Subscriber Name: ___________________________ Relationship to Patient: ____________________

Subscriber Date of Birth: _________________________ Subscriber SSN: ____________________

Address: _______________________________________ Phone: _________________ Gender: _______

Secondary Insurance: ________________________________ Subscriber ID: _____________________

Subscriber Name: ___________________________ Relationship to Patient: ____________________

Subscriber Date of Birth: _________________________ Subscriber SSN: ____________________

Address: ____Phone: _________________ Gender: _______

Primary Care Physician/Referring Physician:

Name of Provider: _______________________________________ Date of last visit:__________________

Phone: _____________________ FAX: _____________________ Email: __________________________

Address: ____________________________________ City: ____________ State: _____ ZIP: _______

Medical History:

Medicine Allergies: _______________________________ What was the reaction? (eg hives):_______________________

Other allergies (eg food): ____________________________ What was the reaction? (eg hives):_______________________

Medical Problems: ____

Past Surgeries (what procedure, when): ____

Current Medication(s): ____

Psychiatric History:

Past psychiatric medication(s), how they worked, duration of treatment:_________________________________

____

Psychiatric hospitalization(s), reason for admission, date, duration of stay: ________________________________

____

Family History:

Any blood relatives with psychiatric conditions, addition problems, other medical conditions (eg cancers, thyroid imbalance etc.):

____

SYSTEMS REVIEW

Please *circle* any conditions that are *presently* causing you a problem and underline those that have caused you problems in the past.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever Sweats Fainting Sleep disturbance Fatigue Nervousness Weight loss Weight gain	Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma	Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbances Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness	Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Hardening of arteries Swollen ankles Poor circulation Palpitations Cold hands or feet Varicose veins	Poor appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice Colitis
EENT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain Double vision Ringing in ears Deafness Nosebleeds Trouble swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands	Neck pain Low back pain Arm pain Shoulder pain Leg pain Knee pain Foot pain Pain/numbness down arms or legs Pain between shoulders Swollen joints Spinal curvature Arthritis Fractures	Painful menstruation Hot flashes Irregular cycle Cramps or back pain Vaginal discharge Nipple discharge Lumps in breast Menopausal symptoms Birth control pills Miscarriages Complications with pregnancy Pregnant? Y / N Week? Other: