QUALITY HEALTH FAMILY MEDICAL CARE
REGISTRATION FORM

Please Print

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's Last Name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status: ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?		(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:			Social Security no.:	Home phone :		
City:	State:		ZIP Code:	Cell phone:		
Occupation:	Employer:			Employer phone:		
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.				
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	❑ Insurance Plan	
Other family members seen here:			Email:			

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.:	
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:		Employer phone no.:	
Is this patient covered by insurance? ❑ Yes ❑ No					
Name of primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

HEALTH HISTORY FORM

To help us meet all your needs please fill out both sides of this form completely in ink. This is a confidential record of your medical history.

Patient Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY

Have you ever had any of the following? Please check all pertinent boxes:

- ☐ Aids or HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Trouble
- ☐ Bladder Infections
- ☐ Bleeding Tendency
- ☐ Blood Transfusions
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Epilepsy/Seizures
- ☐ German Measles
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Infectious Mono
- ☐ Kidney Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Mumps
- ☐ Pneumonia or pleurisy
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis (or Positive PPD test)
- ☐ Ulcer
- ☐ Varicose Veins
- ☐ Venereal Disease (STD)
- ☐ Whooping Cough
- ☐ Other (please list)

_____

_____

☐ A lump, growth, cyst, polyp, tumor or cancer in any location? If "Yes", where? _____

Please list and date any other chronic diseases or serious illnesses you have had:_____

_____

_____

PAST SURGICAL HISTORY

Please list and date any surgical operations you may have had. _____

Have you had any of the following? Please describe

Serious accident/injury _____ _____ Date _____

Broken bones (which ones)_____Date _____

Concussion or head injury _____ Date _____

MEDICATIONS: (PLEASE INCLUDE NON-PRESCRIPTION) & HERBAL SUPPLEMENTS

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Allergies:

Medication /Allergen	Reaction	Medication/Allergen	Reaction
		☐ **Latex Allergy?**	
		☐ **Tape Allergy?**	

Family Medical History:

Name	Age	Age of Death	State of Health	Cause of Death
Father				
Mother				
Brother				
Sister				
Grandmother				
Grandfather				

Has any blood relative ever had any* of *the following? *(*Please include grandparents, aunts, uncles, children, etc.)

Arthritis or Rheumatism _____	Cancer _____	Stroke _____
Asthma/hay fever/allergies _____	Thyroid trouble _____	Diabetes _____
Heart disease _____	Tuberculosis _____	Migraine_____
Kidney disease _____	Bleeding disorder _____	Glaucoma_____
Epilepsy/seizure _____	High Blood Pressure _____	Anxiety or Depression _____

Social History: (Please circle the appropriate response)

Ethnicity (check one): □ Hispanic/Latino □ NOT Hispanic/Latino □ Prefer not to answer

Race: □White □Black or African American □Asian □American Indian/Alaska Native □Other _____ □Prefer not to answer

Language? □English □Spanish □French □Italian □German □Indian □Chinese □Korean □Japanese □Russian

Marital Status	Single	Married	Divorced	Widowed	Separated
Use of Alcohol	Never	Rarely	Moderate	Daily	# of Drinks/week ____ Type of drink _____
Use of Tobacco	Never	Quit	Currently	Packs per day_____	
Living Situation	With Family	With Friends	With Significant Other	Alone	
Dominant Hand	Right	Left			

Occupation_____ ***Place of Birth***_____

FOR WOMEN ONLY

Age at the time of your first menstrual period ___ Periods occur every ___days Periods last___days, Date of last period____

Usual amount of flow (check one) Light □ Medium □ Heavy □

Are your periods frequently irregular?	No	Yes
Are your periods usually painful? before? during? after?	No	Yes
Are you usually tense or irritable before or during periods?	No	Yes
Have you had any vaginal bleeding within the last year other than your period?	No	Yes
Do you feel that you have an unusual amount of vaginal itching/discharge?	No	Yes
Do you have pain during or after intercourse?	No	Yes
Do you have hot flashes?	No	Yes
Have you ever had a discharge containing blood from your breast?	No	Yes

When was your last pelvic exam and pap smear? _____

When was your last mammogram? _____

How many pregnancies have you had? ____ How many children do you have? _____

Have you had any miscarriages or children who died at birth? No Yes (How many? ___)

_____ _____

Signature of Patient or Parent if Minor Date

_____ _____

Signature of Provider

Patient Name _____ Account # _____

Policy Regarding Notification and Discussion of Medical Information
It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail or cell phone. When returning calls and an answering machine picks up, we do not leave a message unless it is an appointment reminder. Information also will not be left with an unauthorized person who may answer the phone. *Unless there is a serious emergency, we will only discuss your medical care with others according to your instructions.*

If you would like to have information released to someone other than yourself, please complete the following:

1. I authorize the medical staff to discuss my medical care with the following people, and will indicate in writing when I wish to change this authorization:

_____ _____
name relationship

_____ _____
name relationship

2. Please list names of authorized people with whom we may leave messages: (Le.-spouse, boyfriend, girlfriend, parent, grandparent, son, daughter, etc).

_____ _____
name relationship

_____ _____
name relationship

3. With whom may we discuss your financial situation?

_____ _____
name relationship

_____ _____
name relationship

4. I authorize the staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

□ yes □ no Home phone_____ □ yes □ no Work phone_____
□ yes □ no Answering Machine_____ □ yes □ no Work Voice Mail_____
□ yes □ no Home-Fax _____ □ yes □ no Work-Fax_____
□ yes □ no Cell phone - Voice Mail_____ □ yes □ no In Person_____

_____ _____
SIGNATURE (patient/guardian) DATE

Pt. Account #_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____ , acknowledge receipt this day from ***QUALITY HEALTH FAMILY MEDICAL CARE*** of a copy of the *"PATIENT PRIVACY NOTIFICATION FORM"* of Quality Health Family Medical Care.

Date: _____ _____

(Patient's Signature)

This "Acknowledgement of Receipt of Notice of Privacy Practices" was not signed by the patient because:

___ Patient refused to sign
___ Emergency prevented obtaining signature
___ Communication barriers prevented obtaining signature
___ Other: _____

Received By:

_____

(Print Name of Staff Member)

(Signature of Staff Member)