

MASTER REGISTRATION

PATIENT INFORMATION

Patient Name: _____ Home Phone # _____
LAST FIRST MI

Address: _____ Work Phone # _____

City: _____ ST _____ Zip _____ Date of Birth ____/____/____

Cell Phone _____ Email address _____

Sex: M F Marital Status _____ Age _____ Employed: Y N _____
(Please circle the appropriate answer)

Patient's Social Security # _____ Employer _____

Billing Address _____
(if different from above)

Referred by _____ Family MD _____

Spouse's (or parent) Name _____

Date of Birth ____/____/____ Social Security Number _____

Person to notify in case of emergency _____

Relationship to patient _____ Emergency phone# _____

Reason for visit _____

INSURANCE INFORMATION

Primary Insurance Company _____ Policy # _____

Employer's Name _____ Group # _____

Relationship of Patient to Policy Holder: Self Husband Wife Child Other
(Please circle the appropriate answer)

Referral Y N Pre-certification Y N HMO PPO POS Other _____ Copayment Amount _____

Secondary Insurance Company _____ Policy # _____

Employer's Name _____ Group # _____

Relationship of Patient to Policy Holder: Self Husband Wife Child Other
(Please circle the appropriate answer)

Referral Y N Pre-certification Y N HMO PPO POS Other _____ Copayment Amount _____

Past Medical History

Illness – Please List All Major Illness

Disease	Number of years	Disease	Number of years

Surgery – Please List Any Surgical Procedures (including childbirth)

Procedure	Date	Procedure	Date

Allergies – Please List Any Known Allergies

Medications – Please List Any Medications You Are Taking

Social History

Smoking	Y	N	I smoke(d) ____ packs per day for ____ years and/or have quit for ____ years
Alcohol	Y	N	I have ____ drinks per day or ____ I drink socially (less than 3 drinks per week)

Family Medical History - Please list any diseases that have affected family members

Father's side	Mother's side