PATIENT REGISTRATION FORM

Name (First/M./Last)_____ Date _____

Gender (circle): M F Birth Date_____ Marital Status (circle): Married Divorced Single

SSN _____ Driver's License Number_____ Expiration Date_____

Address (No P.O. Boxes) _____

City_____State_____Zip_____

Mailing Address (if different from above)_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Preferred Method of Contact (Circle): Home Phone Work Phone Cell Phone Email Mail

Preferred Language _____ Email_____

Race (circle): American Indian/Alaska Native Asian Black/American African

Caucasian Hispanic Indian Middle Eastern Native Hawaiian/Polynesian

Ethnicity (circle): Hispanic/Latino Native Hawaiian/Polynesian Not Hispanic or Latino

Were you referred by your doctor? Y N Doctor's Name _____

How did you choose us? _____

Employer_____ Occupation_____

Address _____

City _____ State_____ Zip_____

PRIMARY INSURED'S INFORMATION

Name(First/M./Last)_____ Birth Date _____

Occupation_____ SSN _____

Employer _____ Address_____

City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION

Name (First/M./Last)_____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Alternate Contact Name (First/M./Last) _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

MEDICAL HISTORY / REVIEW OF SYSTEMS

Name: _____ Height _____ Weight _____

Primary M.D. _____ Do you have any allergies to medications? (circle) Y N

Do you have any non-medication allergies? Y N To what? _____
Do you smoke? (circle): Y N How Much? _____
Do you consume alcoholic beverages? (circle) Y N How Much?_____

Have you had or have any problems with the following? (circle Y or N)

Y	N	Cancer	Y	N	Genitourinary	Y	N	Integumentary (Skin)
Y	N	Cardiovascular	Y	N	Hematologic (Blood)	Y	N	Musculoskeletal
Y	N	Constitutional	Y	N	Hepatitis	Y	N	Neurological
Y	N	Ear/Nose/Mouth/Throat	Y	N	High Blood Pressure	Y	N	Psychiatric
Y	N	Endocrine/Diabetes	Y	N	HIV/Aids	Y	N	Respiratory
Y	N	Gastrointestinal	Y	N	Immunological	Y	N	Stroke

Please Explain _____

_____

Do you have any family members with the following? (circle Y or N)

Y	N	Diabetes	Relation: _____	Y	N	Glaucoma	Relation: _____
Y	N	High Blood Pressure	Relation: _____	Y	N	Cataracts	Relation: _____
Y	N	Cancer	Relation: _____	Y	N	Crossed Eye	Relation: _____

Please provide a list of the following (leave blank if the answer is none)

Medications _____

_____

Medication Allergies _____

_____

Eye Surgeries _____

_____