REGISTRATION / HISTORY

Date _____

Patient's name _____ Single _____ Widowed _____ Married _____ Long Term Partner _____ Divorced _____ Separated _____

Name of spouse/partner _____

If a child, parent's name _____

Street address _____ Phone _____

City _____ State _____ Zip _____

Patient employed by _____ Phone _____

Business address _____

Present position _____ How long held _____

Spouse/Partner employed by _____ Phone _____

Business address _____

Present position _____ How long held _____

Purpose of this appointment _____

In case of emergency, who should be notified _____ Phone _____

Who will pay this account _____

Social Security number _____ Birth date _____

Spouse's/Partner's Social Security number _____ Birth date _____

If using Charge Card, name _____ Card no. _____

If welfare, your number _____ County of _____

Do you have insurance that may cover any part of our professional services..... Yes _____ No _____

If so, name of primary company _____ Policy no. _____

Is policy connected with your union Yes ____ No ____ If yes, name of union _____

Local no. _____ Group no. _____

Social Security no. of policy holder _____

Do you have any other insurance .....Yes _____ No _____

If so, name of secondary company _____ Policy no. _____

Is policy connected with a union Yes ____ No ____ If yes, name of union _____

Local no. _____ Group no. _____

Social Security no. of policy holder _____

(It is necessary that you provide claim forms for all professional services that may be eligible for insurance coverage)

Who may we thank for referring you _____

Comments: _____

_____

_____

_____

_____

_____

Please complete reverse side

Date of last health care examination _____ Current age _____

For what _____

Have you been hospitalized in the last 5 years _____ If so, for what _____

_____

Do you have or have you ever had:

	Yes	No		Yes	No
Anemia	___	___	Abnormal Blood Pressure	___	___
Diabetes	___	___	S___/D___/___		
Epilepsy	___	___	Are you allergic to:		
Hepatitis	___	___	Penicillin	___	___
Rheumatic fever	___	___	Local anesthetic	___	___
Heart murmur	___	___	Medication or Drugs	___	___
Abnormal heart condition	___	___	Women: Are you pregnant	___	___
Abnormal bleeding from a cut	___	___			

If allergic to medications or drugs, indicate which ones _____

Are you taking any medication now _____ If so, for what _____

Other physical conditions we should be aware of _____

_____

_____

Name of your physician _____ Phone _____

Are you receiving care now _____ If so, nature of care _____

Are you now receiving other health care Yes ☐ No ☐

If so, nature of care	Name of doctor	Phone

May we request your health records Yes ☐ No ☐

To whom should we address the request _____

_____

This information was given by _____

Date	Services	Charges	Credits	Balance