Advanced Spine & Rehab / Advanced Family Healthcare

New Patient Registration Form & Confidential Health Information Questionnaire

This information is needed so we can better serve you. To protect your identity and due to the Federal Health Insurance Portability and Accountability Act and HIPPA (Patient Privacy Act) this form should be filled out in its entirety and will become part of your medical record.

Today' Date: _____

Last Name:	First Name:	Middle Name:
Birthdate:	❑ F ❑ M ❑ Other ❑ Prefer not to disclose	Social Security:
Address:		
City, State, and Zip		
Phone #: ( )		
E-Mail Address:		
Occupation (or prior occupation):		
Emergency Contact Name:		
ER Contact Phone #: ( )		
Who referred you to our office?		
Is your visit due to an accident / injury:	❑ Yes ❑ No	
If yes, date of injury:	County where injury occurred:	
Do you have: *Please circle all that apply* Living Will / Durable Power of Attorney / Advance Directive for Health Care		
If yes, please provide us with copies for your medical file.		

I attest and agree that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office is my sole responsibility, despite any insurance plan, legal involvement, or settlement. In addition, I understand and agree that if my account is placed in to collections, I am responsible for any and all collection fees. A copy of this document shall be treated as original.

Patient's Printed Name _____Date _____

Parent or Legal Guardian's Printed Name _____Date_____

Patient's Signature (*if a minor, Parents or Legal Guardian Signature*) _____

INSURANCE COVERAGE INFORMATION

Primary Insurance Company

_____

Address _____

Phone _____

Policy #_____ Group # _____

Policy Holder's Name _____

Birthdate _____ SS#_____

Relationship to patient: (Circle One) Self Spouse Child Other

Employer _____

Employer Phone _____

Secondary Insurance Company

_____

Address _____

Phone _____

Policy #_____ Group # _____

Policy Holder's Name _____

Birthdate _____ SS#_____

Relationship to patient: (Circle One) Self Spouse Child Other

Employer _____

Employer Phone _____

SOCIAL HISTORY		
Tobacco?: ❑ No ❑ Yes	Type/Amount/Frequency:	If stopped, when?:
Alcohol? ❑ No ❑ Yes	Type/Amount/Frequency:	If stopped, when?:
Caffeine?: ❑ No ❑ Yes	Type/Amount/Frequency:	If stopped, when?:

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**

SURGICAL HISTORY *Please describe and date any medical procedures that you have had*

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	☐M ☐ F	
Mother				☐M ☐ F	
Sibling	☐M ☐ F			☐M ☐ F	
Sibling	☐M ☐ F			☐M ☐ F	
Grandmother Maternal/Paternal			Grandfather Maternal/Paternal		

PERSONAL MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Pacemaker or Implanted Defibrillator
- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism / Hyperthyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart attack
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema / COPD
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Other medical conditions (please list):

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES

- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS

- ❑ Ringing in ears
- ❑ Loss of hearing

EYES

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

HEART AND LUNGS

- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES

- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

BLOOD

- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER

- ❑ Frequent or painful urination
- ❑ Blood in urine

THROAT

- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

PSYCHIATRIC

- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

Women Only:

- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

Men Only:

- ❑ Date of last prostate and rectal exam?

_____

WOMEN'S Reproductive History:

Age of first period: # Pregnancies: Miscarriages: # Abortions:

Have you reached menopause? Y/ N age?:

Do you have regular periods? Y / N