Adult Patient Registration Forms Today's Date: _____

Last Name: _____ Home Phone: _____

First Name: _____ Cell Phone: _____

Address:_____ Date of Birth: _____/_____/_____ Age _____

City: _____ State_____ Zip_____ SSN: _____

County:_____ Email Address: _____

Employer: _____ City: _____ Phone: _____

Marital Status: Single Married Divorced Separated Widowed

Gender: ❑ Female ❑ Male

Race: ❑ African Amer/Black ❑ Caucasian/White
❑ Amer Indian/Alaska Native ❑ Hispanic/Latino
❑ Native Hawaiian/Pac Islander ❑ Other

Ethnicity: ❑ Hispanic, Latino, or Spanish Origin
❑ Not Hispanic, Latino, or Spanish Origin

Name of Guardian or POA:
_____

Emergency Contact : _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION (Please give receptionist a copy of your card and Complete)

Primary Insurance: _____
Cardholder: _____
ID No._____ Group No. _____
Relationship to Patient: _____
Date of Birth: _____/_____/ _____
Social Security Number: _____-_____- _____

Secondary Insurance:_____
Cardholder:_____
ID No._____ Group No._____
Relationship to Patient:_____
Date of Birth:_____ / _____ / _____
Social Security Number: _____-_____ - _____

MEDICAL RELEASE INFORMATION

Who may we release medical information to?

1. _____ Phone:_____ Relationship: _____
2. _____ Phone:_____ Relationship: _____

May we leave medical information on the answering machine or voice mail of the phone number(s) you have listed**? Yes No**

Patient Name: _____Date of Birth: _____/_____/_____

REFERRING SECTION (Circle one) **PRIMARY CARE PHYSICIAN**

Family Member _____ Name: _____
Doctor _____
Attorney _____ City: _____

Other _____ Phone: _____

WORK COMP SECTION (Please notify the receptionist with required paperwork and information)

Have you reported this injury to your Employer? Yes No
Have you involved an attorney? Yes No
Work Comp Insurance Company: _____ Claim#:_____
Adjuster: _____Phone:_____
Contact Person for Employer: _____ Phone: _____
How did your injury 0ccur? _____

PATIENT'S PAST MEDICAL HISTORY (*Please check all that apply*) ❑ **NO PAST MEDICAL HISTORY**

- ❑ Anemia
- ❑ Ankle Swelling
- ❑ Anxiety/Panic Attacks
- ❑ Anesthesia Complications
- ❑ Malignant Hyperthermia
- ❑ Arrhythmia
- ❑ Arthritis/Osteoarthritis
- ❑ Asthma/Lung Disease
- ❑ Bleeding Tendency
- ❑ Blood Clots/DVT
- ❑ Blood Thinners
- ❑ Bone/Joint Infection
- ❑ Bruise Easily
- ❑ Bunions
- ❑ Cancer
  - ❑ Chemo ❑ Radiation
- ❑ Cardiac Problems
- ❑ Carpal Tunnel, Neuropathy
- ❑ Chest Pain, Angina
- ❑ Circulatory Problems
- ❑ Cirrhosis, Jaundice
- ❑ Claustrophobia
- ❑ Deafness or hearing trouble
- ❑ Depression
- ❑ Diabetes ❑ 1 ❑ 2
- ❑ Diverticulitis
- ❑ Emphysema or COPD
- ❑ Fainting/loss of consciousness
- ❑ Fatigue/Weakness
- ❑ Gall Stones
- ❑ Gastritis
- ❑ Glaucoma
- ❑ Gout
- ❑ Headaches
- ❑ Heart Attack/MI
- ❑ Heart Condition (congenital)
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ Hiatal Hernia
- ❑ HIV
- ❑ Hypertension (High BP)
- ❑ Irritable Bowel Syndrome
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Kidney Disease
- ❑ Kidney Failure
  - ❑ *Dialysis* ❑ *No Dialysis*
- ❑ Liver Disease
- ❑ Lumbar Disk Disease
- ❑ Lyme Disease
- ❑ Morning Stiffness
- ❑ Multiple Sclerosis
- ❑ Muscle Spasms
- ❑ Muscle Tenderness
- ❑ Muscle Weakness
- ❑ Myasthenia Gravis
- ❑ Numb/Tingling hands/feet
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Palpitations
- ❑ Parkinson's Disease
- ❑ Phlebitis
- ❑ Pneumonia
- ❑ Poly/Fibromyalgia
- ❑ Renal Failure
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Seizures
- ❑ Shortness of Breath
- ❑ Skin Problems/Disorders
- ❑ Sleep Apnea
- ❑ Spinal Stenosis
- ❑ Stroke/TIA
- ❑ TB (Tuberculosis)
- ❑ Thyroid High Low
- ❑ TMJ (Jaw locks or pops)
- ❑ Ulcers/Reflux/GERD
- ❑ Vascular/Circulatory
- ❑ Varicose Veins
- ❑ Vertigo
- ❑ Other_____

I have reviewed this Information, and by my signature, attest that the answers are true and accurate to the best of my ability:

_____ _____
Patient Signature **Date**:

_____ _____
Guardian Signature **Date**