

Patient Registration Form

Patient information					
Last Name	First Name	Middle Name	Suffix	Social Security #	
Gender (circle) M / F	Date of Birth	Marital Status (circle) Divorced - Married - Separated - Single - Widowed - Other		Preferred Language	
Race (check all that apply) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Patient Declined			Ethnicity (check all that apply) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Multiple <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Patient Declined		
Mailing Address			Apt/Lot	City/State	Zip code
			Phone #s: Home () Mobile () Work ()		
Email Address			Primary Physician		
Responsible Party/Parent/Guardian (circle one) Check if same as [] Patient					
Last Name	First Name	Gender (circle) M / F	Date of Birth	What is Patient's relationship to responsible party?	
Mailing Address			Apt/Lot	City/State	Zip code
			Phone #s: Home () Mobile () Work ()		
Employer Information					
Employer		Address		City/State	Zip code
Insurance Information Check if [] Self pay					
Primary Insurance:			Secondary Insurance:		
Insurance Name		Begin date	Insurance Name		Begin date
Subscriber/Member Name		Date of Birth	Subscriber/Member Name		Date of Birth
What is Patient's Relationship to Subscriber?	Gender (circle) M / F	What is Patient's Relationship to Subscriber?		Gender (circle) M / F	
Insurance Mailing Address		City/State	Zip code	Insurance Mailing Address	
		City/State	Zip code		
Subscriber/Member #		Group #		Subscriber/Member #	
				Group #	
Patient Portal					
<p>To receive an invitation to register for the patient portal please ensure you have provided an e-mail address above.</p> <p>Benefits of the patient portal include: 24/7 access online via a computer or smart phone app for yourself or a designated caregiver to view results and visit summaries, request prescription refills, update your demographics, and send secure messages directly to your provider's staff without having to pick up the phone.</p> <p>To opt out of the patient portal please check one of the options below:</p> <p>_____ I am not interested in signing up for the portal at this time _____ I do not have an e-mail address</p>					
Health Information Exchange (HIE)					
<p>I grant Independence Physician Management consent to submit immunizations administered to State Immunization Registry; and to view and/or import all medication history prescribed within the last two years. I authorize Independence Physician Management to search and access my records through a Health Information Exchange (HIE) for purposes of medical treatment. I have the right to opt-out at any time by notifying Independence Physician Management</p>					

Patient/Legal Guardian Signature

Date

Patient/Legal Guardian Print

Date



NEW PATIENT HEALTH HISTORY

Name: (Last, First, M.I.) _____ M F DOB: _____

Date: _____ Marital Status: Single Partner Married Separated Divorced Widowed

Number of children: _____ How many live with you? _____ Occupation is/was? _____ Disabled Yes No

Previous or referring doctor: _____ Date of last physician exam: _____

Reason for today's visit: _____

Personal Health History

Do you have an Advanced Directives? (Advance Directives refer to a person's instructions about future medical care, in the event the person becomes unable to speak for himself/herself. A Living Will is an example of an Advance Directive) Yes No

Are you up to date on your vaccinations? Y N

Pneumonia Y N, Shingles Y N, Tetanus Y N, D-TAP Y N, Influenza Y N Decline

Tests/Screenings and Dates: Mammogram _____ Result: Normal Abnormal, PAP _____ Result: Normal Abnormal,

PSA _____ Result: Normal Abnormal, Colonoscopy _____ Result: Normal Abnormal

Diabetic Eye Exam _____ Result: Normal Abnormal, Diabetic Foot Exam _____ Result: Normal Abnormal,

Dexa Scan _____ Result: Normal Abnormal, Chest X-Ray _____ Result: Normal Abnormal

Surgeries/Hospitalization

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

I have had no surgeries I have never been hospitalized

Have you ever had a blood transfusion? Y N

Please list other physicians you have seen in the last 12 months, and for what reason.

Physician _____ Reason _____

Physician _____ Reason _____

YOUR MEDICAL HISTORY

Asthma <input type="checkbox"/> Y <input type="checkbox"/> N	Gastrointestinal Disease <input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Disease <input type="checkbox"/> Y <input type="checkbox"/> N
Behavioral Disorders <input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack <input type="checkbox"/> Y <input type="checkbox"/> N	Urological Disease <input type="checkbox"/> Y <input type="checkbox"/> N
Cancer <input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N	Arrythmia <input type="checkbox"/> Y <input type="checkbox"/> N
Type: _____	High Cholesterol <input type="checkbox"/> Y <input type="checkbox"/> N	Depression <input type="checkbox"/> Y <input type="checkbox"/> N
Type: _____	Musculoskeletal Disease <input type="checkbox"/> Y <input type="checkbox"/> N	Emphysema/COPD <input type="checkbox"/> Y <input type="checkbox"/> N
Cardiovascular Disease <input type="checkbox"/> Y <input type="checkbox"/> N	Neurological Disorders <input type="checkbox"/> Y <input type="checkbox"/> N	Seizures <input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N	Pulmonary Disease <input type="checkbox"/> Y <input type="checkbox"/> N	Stroke <input type="checkbox"/> Y <input type="checkbox"/> N
Endocrine Disease <input type="checkbox"/> Y <input type="checkbox"/> N	Skin Disease <input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N
Kidney Disease <input type="checkbox"/> Y <input type="checkbox"/> N	STD <input type="checkbox"/> Y <input type="checkbox"/> N	Any other conditions <input type="checkbox"/> Y <input type="checkbox"/> N
	Hepatitis <input type="checkbox"/> Y <input type="checkbox"/> N	or symptoms

List any other past medical problems: _____

List your prescribed medications and any over the counter medications and any vitamins or supplements.

_____ Dose/Frequency _____	_____ Dose/Frequency _____
_____ Dose/Frequency _____	_____ Dose/Frequency _____
_____ Dose/Frequency _____	_____ Dose/Frequency _____
_____ Dose/Frequency _____	_____ Dose/Frequency _____

List additional drugs on back of questionnaire. I take no medications, vitamins, supplements, or any other over the counter medications.

Allergies

Name _____ Name _____

Name _____ Name _____

I have no drug allergies.

FAMILY MEDICAL HISTORY

Please indicate if YOUR FAMILY has a history of the following: (**ONLY** include parents, grandparents, siblings and children)
F- Father, **M-** Mother, **B-** Brother, **S-** Sister, **MGM-** Maternal grandmother, **MGF-** Maternal grandfather,
PGM- paternal grandmother **PGF-** Paternal grandfather

<input type="checkbox"/> I am adopted and do not know biological family history.	<input type="checkbox"/> Family history unknown.	
___ Alcohol Abuse	___ Diabetes	___ Osteoporosis
___ Arthritis	___ Heart Disease	___ Other Cancer
___ Asthma	___ High Blood Pressure	___ Seizures/Convulsions
___ Bleeding Disease	___ High Cholesterol	___ Stoke/CVA of the Brain
___ Breast Cancer	___ Kidney Disease	___ Thyroid Problems
___ Colon Cancer	___ Lung/Respiratory Disease	<input type="checkbox"/> Mother, Grandmother, Sister developed heart disease before the age of 65.
___ Depression	___ Mental Illness	<input type="checkbox"/> Father, Grandfather or Brother developed heart disease before the age of 65.
	<input type="checkbox"/> NONE OF THE ABOVE	<input type="checkbox"/> Other: _____

SOCIAL HISTORY

Exercise Do you exercise? Y N If yes, how many times per week? _____

Caffeine Do you drink caffeine: Y N If yes, Coffee Tea Soda Amount per day? _____

Alcohol Do you drink alcohol? Y N If yes, how many drinks per week? _____

Tobacco Do you use tobacco of any kind? Y N If yes, how many times per day? _____
What type? _____

Drugs Do you currently use recreational or street drugs? Y N If yes, how many times a day? _____
What type? _____

These questions are for WOMEN ONLY

Do you see a Gynecologist? Y N If yes, name of provider? _____

Age at onset of menstruation: _____ Date of last menstruation: _____

Number of pregnancies: _____ Number of live births: _____ Number of Miscarriage/Abortion: _____

These questions are for MEN ONLY

Do you usually get up to urinate during the night? Y N If yes, how many times? _____

Date of last prostate and rectal exam _____

Sexual History

Are you sexually active? Y N With : Men Women Both

Do you use any form of protection? Y N If yes, which type? _____

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____

Pharmacy Information

Local Pharmacy

Patient Name: _____ DOB: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____ Fax Number: _____

Pharmacy Address: _____

Major Cross Streets: _____

Mail Order Pharmacy

Do you use a mail order pharmacy? Y N

If yes, please complete:

Mail Order Pharmacy Name: _____

Phone Number: _____ Fax Number: _____

Address: _____