PATIENT REGISTRATION FORM

Today's Date (mm/dd/yyyy):

PATIENT INFORMATION

Patient Name: (Last, First, MI)	Nickname:	Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Home Phone No.:	Cell Phone No.:	Social Security No.:	Birth Date:	Age:	Sex: M ☐ F ☐

Street Address:	City:	State:	Zip:	E-Mail Address:

Occupation:	Employer:	Employer phone number:

Referred to our clinic by:

☐ Dr. ☐ Insurance ☐ Hospital ☐ Friend ☐ Internet ☐ Other:

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth Date:	Address (if different from above):	Home Phone No.:

Employer:	Occupation:	Employer phone number:

Please indicate primary insurance: ☐ Aetna ☐ Blue Cross ☐ Cigna ☐ Humana ☐ United Healthcare

☐ Medicare ☐ Other Medicare ☐ Tricare ☐ Other:

Name of Policy Holder:	Soc. Security No.	Birth Date:	Policy Number:	Group Number:

**Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Name of secondary insurance:	Name of Policy Holder:	Policy Number:	Group Number:

**Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

IN CASE OF EMERGENCY

Name of emergency contact:	Relationship to patient:	Home Phone No.:	Cell Phone No.:

**The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bee Caves Family Practice or insurance company to release any information required to process my claims.

Patient / Guardian Signature *Date*

NEW PATIENT MEDICAL FORM

Patient Name:
Date:

Medical History

Have you had or currently have any of the following:

☐Acid Reflux/GERD
☐Acne
☐ADD/ADHD
☐Allergies
☐Anxiety
☐Arthritis
☐Asthma
☐Cancer
Type:
☐COPD
☐Depression
☐Diabetes
☐Heart Disease
☐Hypertension
☐Hypothyroidism
☐High Cholesterol
☐Insomnia
☐Obesity
☐Osteoporosis
☐Psychiatric issues
☐STD
Other:
☐
☐
☐

Surgical History (include date)

Family History

Has anyone in your immediate family had any of the following:
M = mother, F = father, S = sibling, MG = maternal grandparents, PG = paternal grandparents

☐Acid Reflux/GERD
☐M ☐ F ☐S ☐MG ☐PG
☐Acne
☐M ☐ F ☐S ☐MG ☐PG
☐ADD/ADHD
☐M ☐ F ☐S ☐MG ☐PG
☐Allergies
☐M ☐ F ☐S ☐MG ☐PG
☐Anemia
☐M ☐ F ☐S ☐MG ☐PG
☐Anxiety
☐M ☐ F ☐S ☐MG ☐PG
☐Arthritis
☐M ☐ F ☐S ☐MG ☐PG

☐Asthma
☐M ☐ F ☐S ☐MG ☐PG
☐Cancer
Type:
☐M ☐ F ☐S ☐MG ☐PG
Type:
☐M ☐ F ☐S ☐MG ☐PG
☐COPD
☐M ☐ F ☐S ☐MG ☐PG
☐Depression
☐M ☐ F ☐S ☐MG ☐PG
☐Diabetes
☐M ☐ F ☐S ☐MG ☐PG

☐Heart Disease
☐M ☐ F ☐S ☐MG ☐PG
☐Hypertension
☐M ☐ F ☐S ☐MG ☐PG
☐Hypothyroidism
☐M ☐ F ☐S ☐MG ☐PG
☐High Cholesterol
☐M ☐ F ☐S ☐MG ☐PG
☐Insomnia
☐M ☐ F ☐S ☐MG ☐PG
☐Obesity
☐M ☐ F ☐S ☐MG ☐PG
☐Osteoporosis
☐M ☐ F ☐S ☐MG ☐PG

☐Psychiatric issues
☐M ☐ F ☐S ☐MG ☐PG
☐STD
☐M ☐ F ☐S ☐MG ☐PG
Other:
☐
☐M ☐ F ☐S ☐MG ☐PG
☐
☐M ☐ F ☐S ☐MG ☐PG
☐
☐M ☐ F ☐S ☐MG ☐PG

Recent Vaccinations

Please indicate approximate date of vaccine (mm/yyyy)

☐DTAP / TDAP
Date:
☐Tetanus
Date:
☐Flu
Date:
☐MMR
Date:
☐Hep A
Date:
☐Hep B
Date:
☐Hib
Date:
☐HPV
Date:
☐Meningococcal
Date:
☐Pneumococcal
Date:
☐Polio
Date:
☐TB skin test
Date:
☐Varicella
Date:
☐Zostavax
Date:

NEW PATIENT MEDICAL FORM

Social History

Living arrangement? ☐with spouse ☐alone ☐with roommate ☐other:
Do you smoke? ☐Yes ☐No
If yes, how many per day? / How many years have you smoked?
Do you drink alcohol? ☐Yes ☐No
Number of drinks per ☐day ☐week?
Do you use illicit drugs? ☐Yes ☐No / Which drug(s):
How often? per ☐day ☐week

When was your last physical exam ? **Doctor's name / practice:**

For women :
Age of initial menses: Date of last menstrual period:
When was your last pap smear? Breast exam?
Do you use birth control? ☐Yes ☐No What method?
Number of pregnancies Number of live births
Number of Cesarean sections
Have you had a hysterectomy? ☐Yes ☐No
If yes, ☐full ☐partial? Date:
Any other female medical history?

Health Screenings *(Please put approximate date performed)*

☐Colonoscopy
Date:
☐Bone Density
Date:
☐Mammogram
Date:
☐Blood work
Date:
☐Echocardiogram
Date:
☐EKG
Date:
☐Prostate screen
Date:
☐Other:
Date: