

Patient Registration Form (eCW)

(Please Print)

PATIENT INFORMATION

Dr. Miss Mr. Mrs. Ms. Sir

Patient's Name (Last) (First) (MI) Previous Name

Address Line 1

City, State ZIP

Home Phone Cell No. Work Phone Ext.

Primary Care Provider (PCP) Referring Provider

Rendering Provider Name (this practice) E-Mail Address:

Date of Birth MM/DD/YYYY Sex F - Female M - Male Transgender

Race American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Black or African American White Declined

Ethnicity Hispanic or Latino Not Hispanic or Latino Declined

Language English Spanish Indian Japanese Chinese Korean French German Russian Other

Marital Status Married Single Divorced Widowed Legally Separated Partner

Social Security Number Employer Name

Employment Status 1 - Full-Time 2 - Part-Time 3 - Not Employed 4 - Self-Employed 5 - Retired 6 - Active Military

Student Status F - Full-Time Student P - Part-Time Student N - Not a Student

Emergency Contact Last Name First Name

Phone Number Do you have a living will? Yes No

Emergency Contact Relationship to Patient Guardian

Address Line 1

City, State ZIP

Home Phone Work Phone Ext.

Referring Provider Name

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party Another Patient Guarantor Self Check here if information is same as patient

Responsible Party Name (Last) (First) (MI)

Guarantor Account Number Date of Birth MM/DD/YYYY

Social Security Number Telephone

E-Mail Address Sex F - Female M - Male

Address Line 1

City, State ZIP

Employer Employer Phone Number

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number

Name of Insured Patient Relationship to Insured

Subscriber ID (Policy Number) Group ID Copay Amount

Effective Date Termination Date Date of Birth MM/DD/YYYY

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number

Name of Insured Patient Relationship to Insured

Subscriber ID (Policy Number) Group ID Copay Amount

Effective Date Termination Date Date of Birth MM/DD/YYYY

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature Date

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Patient History

Name: _____ Date of Birth: ____ / ____ / ____ Age _____

Referring Physician: _____

Primary Care Physician: _____

Briefly Describe Your Present Symptoms: _____

When symptoms began (approximate): _____

REVIEW OF SYSTEMS:

Do you have or have you ever had any of the following:

Constitutional

Recent Weight Gain Yes No

If yes, how much? _____ Yes No

Recent Weight Loss Yes No

If yes, how much? _____ Yes No

Fatigue Yes No

Weakness Yes No

Fever Yes No

Eyes

Wear Glasses or Contacts Yes No

Double or Blurred Vision Yes No

Glaucoma Yes No

Ear, Nose, and Throat

Hearing Loss Yes No

Sinus Problems Yes No

Difficulty Swallowing Yes No

Cardiovascular

Chest Pain Yes No

Irregular Heartbeat Yes No

High Blood Pressure Yes No

Swelling of Hands, Feet, Ankles Yes No

Heart Murmurs Yes No

Palpitations Yes No

Gastrointestinal

Nausea Yes No

Vomiting Yes No

Abdominal Pain Yes No

Constipation Yes No

Diarrhea Yes No

Blood in Stool Yes No

Heartburn Yes No

Hemorrhoids Yes No

Hematologic/Lymphatic

Swollen Glands Yes No

Anemia Yes No

Transfusion (When _____) Yes No

Phlebitis Yes No

Respiratory

Hoarseness Yes No

Wheezing/History of Asthma Yes No

Shortness of Breath Yes No

Cough Yes No

Genitourinary

Frequent Urination Yes No

Burning or Painful Urination Yes No

Blood in Urine Yes No

Kidney Stones Yes No

Musculoskeletal

Joint Pain Yes No

Muscle Pain or Cramp Yes No

Joint Stiffness or Swelling Yes No

Weakness of Muscles/Joints Yes No

Back Pain Yes No

Integumentary

Rash or Itching Yes No

Easy Bruising Yes No

Change in Hair or Nails Yes No

Neurological

Frequent Headaches Yes No

Light-headed or Dizziness Yes No

Seizures or Convulsions Yes No

Stroke Yes No

Fainting Yes No

Psychiatric

Anxiety Yes No

Depression Yes No

Sleep Problems Yes No

Endocrine

Thyroid Disease Yes No

Diabetes Yes No

Excessive Thirst Yes No

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Patient History

SOCIAL HISTORY:

Marital Status: Single Married Separated Divorced Widowed

Do you currently use tobacco products? Yes No

If yes, quantity per day: Cigarettes _____ Cigars _____ Chewing Tobacco _____

Started Age/Year: _____ Stopped Age/Year: _____

Have you used illicit drugs? Yes No

Are you currently using illicit drugs? Yes No

Do you currently drink alcohol? Yes No

Number per week: Beer _____ Wine _____ Distilled Spirits _____

Do you exercise regularly? Yes No

FAMILY HISTORY:

	Age	If Living Medical History	Age	If Deceased Cause of Death
Father				
Mother				
Sibling				
Sibling				
Sibling				

PAST MEDICAL HISTORY:

Please check if you now have or have ever had any of the following:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Jaundice | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Colitis |

SURGICAL HISTORY:

List all surgeries: when the surgery was performed and who performed the surgery.

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Patient History

DIABETES:

Are you a Diabetic? Yes No

 If yes, do you take oral medication for DM? Yes No

Are you on Dialysis? Yes No

 If yes, where? _____ What days? _____

MEDICATIONS:

Drug Allergies: _____

Are you allergic to **LATEX?** Yes No

Are you allergic to **CONTRAST DYE OR IODINE?** Yes No

Current Medications

Please list all medications you are currently taking including over-the-counter and herbal medications.

Medication	Dosage	Frequency

Patient Signature _____ Date _____

Physician Signature _____ Date _____