Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: ______________________ (last name) ______________________ (first name) ________ (initial)

Date of Birth: ____ / ____ / ______ Social Security #: ______ - ______ - _________ Personal Email ONLY: ______________________

(No work related email in accordance with HIPAA)

Home Phone: (_____) ________________ Work Phone: (_____) ________________ Cell Phone: (_____) ________________

Address: ______________________ Apt. #: ______ City: ______________ State: ____ Zip: __________

PATIENT'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________

Name: ______________________ (last name) ______________________ (first name) ________ (initial)

Date of Birth: _______ / _______ / _______ Social Security #: _______ - _______ - _______

Home Phone: (_____) ________________ Work Phone: (_____) ________________ Cell Phone: (_____) ________________

Address: ______________________ Apt. #: ______ City: ______________ State: ____ Zip: __________

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: ______________________________________

Address: ______________________ City: ______________ State: ____ Zip: __________

Name of insured: ______________________ Date of Birth: ____________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ______________________ Group #: ______________________

SECONDARY Insurance Name: ______________________________________

Address: ______________________ City: ______________ State: ____ Zip: __________

Name of insured: ______________________ Date of Birth: ____________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ______________________ Group #: ______________________

PATIENT'S REFERRAL INFORMATION

Name: ______________________________________ Relationship: ______________________

Address: ______________________ City: ______________ State: ____ Zip: __________

Phone: (_____) ________________ Fax: (_____) ________________

PHARMACY INFORMATION

Name: ______________________________________

Address: ______________________ City: ______________ State: ____ Zip: __________

Phone: (_____) ________________ Fax: (_____) ________________

EMERGENCY CONTACT

Name: ______________________________________ Relationship: ______________________

Address: ______________________ City: ______________ State: ____ Zip: __________

Home Phone: (_____) ________________ Work Phone: (_____) ________________ Cell Phone: (_____) ________________

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Nezhat Medical Center and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ______________ Your Signature: ______________________________________

NEZHAT MEDICAL CENTER

Name: ______________________________ Date of Birth: ________________ Date: __________

Patient History Form

Please complete this form as accurately as possible. Use blue or black ink and please print.

General Medical History - *Please check all that apply.*

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Hepatitis – Type __________
- ☐ Phlebitis (blood clot in leg)
- ☐ Pulmonary embolus (blood clot in lung)
- ☐ Other ______________________________

____

List all surgical procedures (inpatient and outpatient).

Type of Surgery	Date	Findings

Have you been hospitalized other than stated above? If yes, please provide the details.

____

____

Are you allergic to any medications? If yes, please list the medication(s) and your reaction to it.

____

____

Please list current medications

____

____

Review of Systems – *Please circle all that apply.*

CNS:	Multiple Sclerosis Convulsions Migraine headaches Blind spots
Respiratory:	Coughing up blood Emphysema Asthma
Cardiovascular:	Chest pain with exertion Shortness of breath Sleep on more than 1 pillow
GI:	Ulcers Gall bladder disease Blood in stool Dark black stool
GU:	Bladder infections Kidney infections Blood in urine
	Burning with urination Urine leakage
Musculoskeletal:	Numbness Weakness Arthritis

Have you experienced a recent weight loss or gain of more than 10 pounds? Loss____ Gain ____

NEZHAT MEDICAL CENTER

Name: ______________________________

Family History – *List all serious illnesses and age of onset. State age and cause of death if applicable.*

Mother: ____

Father: ____

Sisters: ____

Brothers: ____

YES	NO	
☐	☐	Has anyone in your family had breast cancer? If yes, who? _________________________________ Age of onset? __________
		Has anyone in your family had any of the following? Please list relationship to you.
☐	☐	Cancer
☐	☐	Alcoholism
☐	☐	Osteoporosis
☐	☐	Hip Fractures
☐	☐	Inherited diseases, such as hemophilia, muscular dystrophy, cystic fibrosis, diabetes, thyroid problems, high cholesterol.
☐	☐	Birth defects or open spine defect (spina bifida, anencephaly)
☐	☐	Mental retardation
☐	☐	Still-born infants
☐	☐	If you are Black, have you been tested for sickle cell trait? Results: ______________
☐	☐	If you are Jewish, have you been tested for Tay Sachs disease? Results: __________

Social History

Occupation: ____

☐	☐	Do you smoke? If yes, how many packs per day? ________ How long? __________
☐	☐	Do you drink alcohol? If yes, how many drinks per week? _____________________ (one beer = one glass of wine = 1 ½ ounces of liquor)

Please list any countries outside of the United States where you have lived.____________________

____

List regular exercise: _________________________________ # of times per week: ____________

Is there anything you would like us to know about your beliefs, religion, or lifestyle that may affect your health or healthcare? ____

____

NEZHAT MEDICAL CENTER

Name: ______________________________

Menstrual, Gynecologic, & Sexual History

We understand that these questions are very personal. Please be assured that we will keep this information in strict confidence. None of the information on the following pages will be released to anyone, at any time, unless you specifically request such.

YES	NO	
☐	☐	Are your periods regular? Occur every ________ days, lasting _______ days. If irregular, how long have they been irregular? _____________________________
☐	☐	Do you have bleeding between periods?
☐	☐	Do you have pain with your periods? If yes, is this new or have you always had pain with your periods? ____
☐	☐	Do you have pain before, during or after your periods? _______________________
☐	☐	Do you have pain with intercourse?
☐	☐	Do you have bleeding with intercourse?
☐	☐	Do you have pain with bowel movements?
☐	☐	Do you presently have a discharge, itching, and/or odor? If yes, please describe the symptoms: _____________________________________
☐	☐	Do you have symptoms of menopause or hormone imbalance? If yes, please describe the symptoms: _____________________________________
☐	☐	Do you have any significant premenstrual symptoms? Anxiety Depression Bloating Headaches Breast tenderness
☐	☐	Did your mother take DES when she was pregnant with you?
☐	☐	Have you had an abnormal Pap smear? If yes, when? _________________________ Treatment ______________________________ Outcome _____________________
☐	☐	Have you had any sexually transmitted diseases? If yes, please list dates. Herpes ________________________ Gonorrhea ________________________ Chlamydia _____________________ PID ______________________________ Condyloma (warts - HPV) _________________________
☐	☐	Do you currently suspect any sexually transmitted disease?
☐	☐	Have you had sexual contact with a person who is at risk for HIV?

Age of first intercourse:	____ under 19	____ 19 or over
Total number of partners:	____ less than 3	____ 3 or more
Total number at present:	____ 0-1	____ 2 or more

YES	NO	
☐	☐	Are you able to become sexually aroused?
☐	☐	Are you able to have an orgasm?
☐	☐	Do you have any problems with sex? If yes, please describe. ___________________ ____
☐	☐	Do you consider yourself to be homosexual?

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Name: ______________________________

How old were you when your periods started? ___________

First day of last menstrual period: ____________________

Current method of birth control: _____________ How long have you used this method?_________

Have you ever used and IUD for birth control? __________ If yes, how long? _________________

Total number of pregnancies: ______________

Please list dates and outcomes of pregnancies:

Full-term____

Premature____

Miscarriage____

Abortion____

Number of living children______________

If you have endometriosis, when were you diagnosed: ____________________________________

What is the extent of endometriosis? Mild Moderate Severe

Have you taken any of the following medications for endometriosis? If yes, give dates and dosage.

Danocrine____

Lupron____

Progesterone____

Birth Control Pills____

Pain Medications____

Other____

Date of most recent Pap smear: _________________ Results: _____________________________

Date of most recent mammogram: ________________ Results: _____________________________

Date of most recent colonoscopy: ________________ Results: _____________________________

Date of most recent bone density scan: ________________ Results: _________________________

Please use this space if you would like to describe anything in greater detail.

____

____

____

____

____

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Name: ______________________________

Place a check next to any of the following symptoms you currently have based on severity (severe, moderate, mild).

	Severe	Moderate	Mild
Acne	_____	_____	_____
Anxiety	_____	_____	_____
Bloating	_____	_____	_____
Body aches	_____	_____	_____
Breast tenderness	_____	_____	_____
Cravings (carbs, salt, chocolate,etc.)	_____	_____	_____
Mood swings	_____	_____	_____
Depression	_____	_____	_____
Dry skin	_____	_____	_____
Edema/swelling	_____	_____	_____
Excessive facial or body hair	_____	_____	_____
Fatigue	_____	_____	_____
Hot flashes	_____	_____	_____
Insomnia	_____	_____	_____
Irritability	_____	_____	_____
Lethargy/tired	_____	_____	_____
Low sex desire	_____	_____	_____
Memory loss	_____	_____	_____
Migraines	_____	_____	_____
Night sweats	_____	_____	_____
Oily skin	_____	_____	_____
PMS	_____	_____	_____
Reactive/more emotional	_____	_____	_____
Urinary frequency	_____	_____	_____
Urinary leakage	_____	_____	_____
Urinary urgency	_____	_____	_____
Vaginal dryness	_____	_____	_____

Weight gain _____ lbs. over _____ months

Weight loss _____ lbs. over _____ months

Other symptoms (please list):

____

____

____

____