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 #: ____ - ____ - _____ Email: _____

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: _____

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 ____

Name: _____Date of Birth: _____ Date: _____

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? _____

_____

Name: _____Date of Birth: _____ Date: _____

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?

Name: _____Date of Birth: _____ Date: _____

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: _____

Date of most recent mammogram: _____

Date of most recent colonoscopy: _____

Date of most recent bone density scan: _____

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

_____

_____

_____

_____

_____

Nezhat Medical Center

Name: _____ Date: _____

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	_____	_____	_____
Mood swings/ feeling down	_____	_____	_____
Dry skin	_____	_____	_____
Excessive facial or body hair	_____	_____	_____
Fatigue	_____	_____	_____
Hot flashes	_____	_____	_____
Insomnia	_____	_____	_____
Low sex desire	_____	_____	_____
Memory loss	_____	_____	_____
Night sweats	_____	_____	_____
Oily skin	_____	_____	_____
PMS	_____	_____	_____
Urinary frequency	_____	_____	_____
Urinary leakage	_____	_____	_____
Urinary urgency	_____	_____	_____
Vaginal dryness	_____	_____	_____
Weight gain	_____ lbs. over _____ months		
Weight loss	_____ lbs. over _____ months		