

PATIENT REGISTRATION

___ID ___Ins

Date: _____

Name: _____ Date of Birth: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Tel #: () _____ Cell Phone #: () _____ Work Phone #: () _____

May we contact you at any of these numbers? _____ May we leave a message if you are not available? _____

Marital Status: Single Married Divorced Separated Widowed Spouse's Name: _____

Emergency Contact _____ Relationship: _____ Phone number(s): _____

PATIENT EMPLOYER INFORMATION

Employer Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip Code: _____

If employed by EPISD, do you work a minimum of 20 hours per week? YES NO

INSURED PERSON (If NOT patient) Name of insured: _____ Date of Birth: _____

Social Security #: _____ Relationship to patient: _____

INSURANCE INFORMATION

Primary Insurance: _____ Tel #: _____ Group #: _____

Secondary Insurance: _____ Tel #: _____ Group #: _____

Medicaid # (if applicable): _____ Medicare # (if applicable): _____

GENERAL MEDICAL INFORMATION

List any over-the-counter medications you are currently taking: _____

List any prescription medications you take: _____

List any allergies to medications: _____ foods: _____

Name(s) of your primary care physician or other physicians you see: _____

List any surgeries you have had: _____

PERSONAL MEDICAL HISTORY

Have you ever smoked? **YES NO** If yes, are you still smoking? **YES NO** If not, when did you quit: _____

How often do you drink alcohol: never rarely weekly monthly daily If so, how many ounces or beers on average: _____

How often do you drink caffeine: never rarely weekly monthly daily If so, how many cups/glasses on average: _____

FEMALES:

Do you menstruate: **YES NO** If so, are your periods regular: **YES NO** Name of gynecologist: _____

Are you pregnant, planning a pregnancy, or nursing a child? **YES NO**

What type of contraception do you use: Pill Patch Injection Condoms IUD Sterilization Other: _____

How many times have you been pregnant: _____ Number of children: _____ Any miscarriages? **YES NO**

Have you ever experienced or have been diagnosed with any of the following (check all that apply):

<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	Broken Bone(s)
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Bladder Problems
<input type="checkbox"/>	Skin Disorder	<input type="checkbox"/>	Chest pain/pressure/tightness	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Difficulty Hearing	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Frequent Urinary Infections
<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Peptic Ulcer
<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	Seasonal/Perennial Allergies	<input type="checkbox"/>	Bruising or Bleeding Easily
<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Recurrent Diarrhea
<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Chronic Constipation
<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Digestive Disorder
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Acid Reflux
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Males: Prostate Disorder
<input type="checkbox"/>	Excessive Fatigue	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	Difficulty Chewing	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	STDs
<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Other: _____

IMMUNIZATIONS (Check if you have had)

<input type="checkbox"/>	Measles, Mumps, Rubella (MMR)	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Tetanus	<input type="checkbox"/>	Hepatitis A Series
<input type="checkbox"/>	Varicella (Chickenpox)	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Hepatitis B Series
<input type="checkbox"/>	Tuberculosis (TB) either BCG or PPD	<input type="checkbox"/>	Smallpox				

Have you had any of the following tests/studies done? If so, indicate any **ABNORMAL** results.

<input type="checkbox"/>	Bone Density _____	<input type="checkbox"/>	Endoscopy _____	<input type="checkbox"/>	Males: Prostate Exam _____
<input type="checkbox"/>	Electrocardiogram (EKG) _____	<input type="checkbox"/>	Colonoscopy _____	<input type="checkbox"/>	Males: PSA level _____
<input type="checkbox"/>	Stress Test _____	<input type="checkbox"/>	Females: Mammogram _____	<input type="checkbox"/>	Females: Pap smear _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AUTHORIZATION

I certify that the above information is complete and true. I hereby consent to any necessary medical treatment for myself or the minor named below for whom I am legally responsible. Authorization is hereby granted for release of any information required to process any insurance claims and/or Department of Transportation Physicals. I understand that the services from the Employee Health Resource Center are provided at no cost to me; however, I am responsible for any incurred fees from labwork and/or diagnostic testing or for negotiating a settlement on a disputed claim.

Signature: _____ Date: _____

Name of minor (if patient under 18 years old): _____