Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ **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			**Respiratory**		
Recent Weight Gain	Yes	No	Hoarseness	Yes	No
If yes, how much?_____	Yes	No	Wheezing/History of Asthma	Yes	No
Recent Weight Loss			Shortness of Breath	Yes	No
If yes, how much?_____	Yes	No	Cough	Yes	No
Fatigue	Yes	No	**Genitourinary**		
Weakness	Yes	No	Frequent Urination	Yes	No
Fever	Yes	No	Burning or Painful Urination	Yes	No
Eyes			Blood in Urine	Yes	No
Wear Glasses or Contacts	Yes	No	Kidney Stones	Yes	No
Double or Blurred Vision	Yes	No	**Musculoskeletal**		
Glaucoma	Yes	No	Joint Pain	Yes	No
Ear, Nose, and Throat			Muscle Pain or Cramp	Yes	No
Hearing Loss	Yes	No	Joint Stiffness or Swelling	Yes	No
Sinus Problems	Yes	No	Weakness of Muscles/Joints	Yes	No
Difficulty Swallowing	Yes	No	Back Pain	Yes	No
Cardiovascular			**Integumentary**		
Chest Pain	Yes	No	Rash or Itching	Yes	No
Irregular Heartbeat	Yes	No	Easy Bruising	Yes	No
High Blood Pressure	Yes	No	Change in Hair or Nails	Yes	No
Swelling of Hands, Feet, Ankles	Yes	No	**Neurological**		
Heart Murmurs	Yes	No	Frequent Headaches	Yes	No
Palpitations	Yes	No	Light-headed or Dizziness	Yes	No
Gastrointestinal			Seizures or Convulsions	Yes	No
Nausea	Yes	No	Stroke	Yes	No
Vomiting	Yes	No	Fainting	Yes	No
Abdominal Pain	Yes	No	**Psychiatric**		
Constipation	Yes	No	Anxiety	Yes	No
Diarrhea	Yes	No	Depression	Yes	No
Blood in Stool	Yes	No	Sleep Problems	Yes	No
Heartburn	Yes	No	**Endocrine**		
Hemorrhoids	Yes	No	Thyroid Disease	Yes	No
Hematologic/Lymphatic			Diabetes	Yes	No
Swollen Glands	Yes	No	Excessive Thirst	Yes	No
Anemia	Yes	No			
Transfusion (When_____)	Yes	No			
Phlebitis	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:

	If Living		If Deceased	
	Age	**Medical History**	**Age**	**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:

- ❑ Cancer
- ❑ Leukemia
- ❑ Stomach Ulcers
- ❑ Tuberculosis
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Psoriasis
- ❑ Asthma
- ❑ Pneumonia
- ❑ HIV/AIDS
- ❑ Kidney Disease
- ❑ Goiter
- ❑ Emphysema
- ❑ Rheumatic Fever
- ❑ 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 _____