Glaser Family Medical Center PLLC

Patient Registration Information

PATIENT'S PERSONAL INFORMATION

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

Name: ____
last name first name middle initial

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

Home Phone: (_____) _______________Work Phone: (_____) ____________________Cell Phone: (_____) _________________

Address:____ City:________________

State:______________ Zip:____________

PATIENT'S/RESPONSIBLE PARTY INFORMATION

Relationship to Patient: Self Spouse Child Other: __________________

Name:____
last name first name middle initial

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

Home Phone: (_____) _________________ Work Phone: (_____) _________________ Cell Phone: (_____) __________________

Address: ____ City: ________________

State: _______________ Zip:____________

INSURANCE INFORMATION

PRIMARY Insurance Name:____

Address: ____ City: _____________________

State:_______________ Zip: ___________

Name of insured: ___________________________________ Date of Birth: ______________

Relationship to insured: Self Spouse Child Other

Policy #: ______________________SS#_________________ Group #: ____________________________ Copay: $ __________

SECONDARY Insurance Name: ____

Address: ____ City: ____________________

State: ______________ Zip:____________

Name of insured: __________________________________ Date of Birth: ______________

Relationship to insured: Self Spouse Child Other

Policy #: ______________________________________ Group #: ______________________________

Copay: $ __________

WHO REFERRED YOU TO US?

Name/Source: ____

PHARMACY INFORMATION

Name: ____

Address: ____ City:____________________

State: _______________ Zip:____________

Phone: (_____) ____________________ Fax: (_____) ___________________

EMERGENCY CONTACT INFORMATION

Name: ____ Relationship: ____________________

Address: ____ City: ____________________

State: ________________ Zip: ____________

Home Phone: (_____) __________________ Work Phone: (_____) ________________Cell Phone: (_____) ________________

Assignment of Benefits Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Glaser Family Medical Center PLLC, 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: ____

PAST MEDICAL HISTORY

High Blood Pressure	yes/no	Depression/Anxiety	yes/no	Diabetes	yes/no
High Cholesterol	yes/no	Bipolar Disorder	yes/no	Osteoporosis	yes/no
Asthma	yes/no	Hypothyroid	yes/no	Irreg Heart Beat	yes/no
COPD	yes/no	Hyperthyroid	yes/no	Blood Clots	yes/no
Heart Attack	yes/no	Gall Stones	yes/no	Colon Polyps	yes/no
Sleep Apnea	yes/no	GERD	yes/no	Hepatitis	yes/no
TB	yes/no	Ulcer	yes/no	Kidney Disease	yes/no
Kidney Stones	yes/no	Endometriosis	yes/no	Erectile Dysfun	yes/no
Urinary Incont	yes/no	Fibromyalgia	yes/no	Gout	yes/no
Arthritis	yes/no	Lupus	yes/no	Sjogren's	yes/no
Alzheimer's	yes/no	Stroke/TIA	yes/no	Dementia	yes/no
Migraine	yes/no	Multiple Sclerosis	yes/no	Parkinson's	yes/no
Seizures	yes/no	Heart murmur	yes/no	Chronic Pain	yes/no
Anemia	yes/no	Sickle Cell	yes/no	Thallesemia	yes/no
Allergies	yes/no	Psoriasis	yes/no	Glaucoma	yes/no
Cataract	yes/no	Herpes	yes/no	HIV/AIDS	yes/no
Cancer	yes/no	**Other:** ____			

PAST SURGICAL HISTORY

Please list all surgeries and dates:

1.____

2.____

3.____

4.____

FAMILY HISTORY

Relation	Medical Problems	Age at Death	Living/ Deceased
Father			
Mother			
Brothers #			
Sisters #			
Children #			
Extended Fam			

PREGNANCY/GYNECOLOGICAL HISTORY

Pregnancies # _________ First day of last menstrual cycle: _______
Children # _________ Current Birth control: ________
Abortions # _________ Age Periods Started: _________
Miscarriages # _________ Age at Menopause: __________

Last Pap Smear: __________ Result: __________ Last Mammogram: _________ Result: __________

Preventative Health

Last Bone Density Scan: __________ Result: __________
Last Colonoscopy: __________ Result: __________
Last Tetanus Shot: __________

SOCIAL HISTORY

Occupation: ____________________
Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Number of Children: ______
Hobbies:________________________
Exercise (type): __________________
- ☐ Daily
- ☐ Rarely
- ☐ Never

Sexual Activity:
- ☐ Abstinent
- ☐ Monogamous Relationship
- ☐ Multiple Partners
- ☐ No Prior Sexual Activity

Caffeine: ________________ drinks/day
Smoking:
- ☐ Never
- ☐ Now: How much? ______________
- ☐ In past: When did you quit? ______

Tobacco:
- ☐ Cigarettes
- ☐ Cigar
- ☐ Smokeless (Chew)

Illicit Drugs:
- ☐ No
- ☐ Yes: Which? _______________________
- ☐ In past

Alcohol:
- ☐ None
- ☐ Current alcoholic
- ☐ Past alcoholism

How often do you use alcohol?
- ☐ Occasional Binge
- ☐ Rare
- ☐ Regular
- ☐ Social

MEDICATION LIST

Name of Medication	Strength	Number of times daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Vitamins and supplements:
1.
2.
3.
4.
5.

Medication Allergies

Drug ____________________________ Reaction ____
Drug ____________________________ Reaction ____
Drug ____________________________ Reaction ____
Drug ____________________________ Reaction ____
Drug ____________________________ Reaction ____

Do you see any specialist? List the name of the specialist/type/phone number.

1. ____
2. ____
3. ____
4. ____
5. ____