Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Name: _____ _____ _____
last name first name initial

Gender: Male __ Female __ Social Security #_____Marital Status_____ _Date of Birth_____

Race: Declined__ American Indian or Alaska Native___ Asian___ Black or African American___ Native Hawaiian or other Pacific Islander___
White___ Other Race___

Ethnic Group: Declined___ Hispanic or Latino___ Not Hispanic or Latino___

Address: _____

Line 2 _____

Zip_____ **City**_____**State**_____**Country**_____

Phone: **Home**_____**Cell**_____**Work** _____**Ext**_____

E-Mail_____

Preferred Method of Contact : Phone___ Text Message___ Mail___ E-Mail___ Secure E-Mail___(not yet available) Patient Portal ___(not yet available)

Preferred Reminder Method: Phone- Cell___ Home___ Work___ Mail___ E-Mail___

PATIENT 'S EMPLOYER

Name: _____ Occupation: _____

Address: _____ 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 #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

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

Policy #: _____ Group #: _____ Copay: $ _____

PATIENT'S REFERRAL INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

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

PHARMACY INFORMATION

PLEASE NOTE WE SEND MOST PRESCRIPTIONS ELECTRONICALLY

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 authorization for payment of insurance benefits to be made directly to Sislen & Associates, 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: _____

Medical History Form

Name:	Date of Birth:	Date:

☐ Chills ☐ Fatigue ☐ Fever ☐ Sweating at night ☐ Weight gain ☐ Weight loss ☐ Blurred vision ☐ Eye drainage ☐ Eye pain ☐ Use of glasses ☐ Light sensitivity ☐ Ear pain ☐ Decreased hearing ☐ Ringing in the ears ☐ Nose bleeds ☐ Nasal congestion ☐ Nasal sore/ulcer ☐ Bleeding gums ☐ Dentures ☐ Hoarseness ☐ Mouth sore/ulcer ☐ Sore throat ☐ Sore tongue ☐ Tooth pain ☐ Chest pain ☐ Calf muscle pain ☐ Dizziness ☐ Shortness of breath when laying flat ☐ Palpitations ☐ Swelling of feet/legs ☐ Fast heart rate ☐ Varicose veins ☐ Recent cough ☐ Chronic cough ☐ Shortness of breath	☐ Exposure to tuberculosis ☐ Coughing up blood ☐ Chest pain when breathing ☐ Wheezing ☐ Abdominal pain ☐ Heart burn symptoms ☐ Anorexia ☐ Bloating ☐ Difficulty swallowing ☐ Clay-colored stools ☐ Constipation ☐ Diarrhea ☐ Vomiting blood ☐ Red Blood in stools ☐ Hemorrhoids ☐ Black, tarry stools ☐ Nausea ☐ Vomiting ☐ Painful swallowing ☐ Change in stool size/shape ☐ Painful urination ☐ Sores on genital area ☐ Blood in urine ☐ At risk for sexually transmitted diseases ☐ Unprotected sex ☐ Urinary tract infections ☐ Difficulty with erections ☐ Urinating at night ☐ Frequent urination ☐ Urine incontinence ☐ Change in urine stream ☐ Joint pain ☐ Back pain ☐ Joint stiffness	☐ Leg/arm pain ☐ Muscle aches ☐ Acne ☐ Abnormal mole ☐ Very dry skin ☐ Fungal nail infection ☐ Yellow tint to skin or eyes ☐ Itching of skin ☐ Rash ☐ Wart ☐ Loss of balance ☐ Dizziness ☐ Fainting ☐ Headaches ☐ Memory Loss ☐ Numbness or tingling ☐ Seizures ☐ Tremor ☐ Sensation of room spinning ☐ Weakness ☐ Easy bruising ☐ Excessive bleeding ☐ History of blood transfusions ☐ Enlarged lymph glands ☐ Enlarging hands/feet ☐ Hair loss ☐ Cold/heat intolerance ☐ Infertility ☐ Excessive thirst ☐ Excessive appetite ☐ Excessive sweating ☐ Allergies ☐ Frequent infections	☐ Risk for HIV ☐ Hives ☐ Anxiety ☐ Crying spells ☐ Depression ☐ Feelings of stress ☐ Lack of motivation ☐ Personality change ☐ Difficulty focusing ☐ Recreational drug use ☐ Sadness ☐ Insomnia ☐ Suicidal thoughts **FEMALES** ☐ Thick facial hair ☐ Breast disease ☐ Severe pain with periods ☐ Irregular periods ☐ Pain/bleeding after sex Date of last period_____ No. of pregnancies_____ No. of live births_____ **MALES** ☐ Testicular mass/pain ☐ Enlarged scrotal veins ☐ Prostate issues Approximate date of last: Chest x-ray_____ EKG_____ Tuberculosis test_____ Pap smear_____ Tetanus vaccination_____

MEDICATIONS – Please list all that you are taking including nonprescription drugs **ALLERGIES**

HOSPITALIZATIONS – Please list past hospitalizations

Year	Illness or Operation

FAMILY HISTORY – If any blood relative has suffered any of the following please check the box and indicate which relative

Diabetes_____	Stroke_____	Colon Cancer_____	Depression____	Thyroid_____
High Cholesterol_____	Hypertension_____	Breast Cancer_____	Rheumatoid	Lupus_____
Heart Disease_____	Kidney Disease_____	Ovarian Cancer____	Arthritis_____	Other_____

SOCIAL HISTORY

With whom do you live?_____

Do you (have you) smoke(d)?	☐ Yes	☐ No	If yes, how much and for how long?_____
Do you drink alcohol?	☐ Yes	☐ No	If yes, how much and for how long?_____
Do you exercise regularly?	☐ Yes	☐ No	If yes, describe_____
Do you currently work?	☐ Yes	☐ No	List present and past occupations_____

Sign:_____ Date:_____