PATIENT REGISTRATION

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____/_____/_____ Email address: _____

Primary phone number: _____-_____-_____ Alternative phone number: _____-_____-_____

Have you been seen as a patient at this facility? ☐ Yes ☐ No

If yes, please complete questions below.

If no, complete HIPAA then go to New Patient Information.

Since your last visit, have you had any changes to the following	Yes	No	Comments (Please provide new information)
Home address			
Phone number			
Insurance Information			

HIPAA REQUIREMENT

This section is **REQUIRED** for the treatment of ALL (Adult & Minor) patients

Please list names of any person who may have access to patient's information.

Name: _____ Relationship to Patient: _____

Date of Birth: _____/_____/_____ Phone Number: _____

Name: _____ Relationship to Patient: _____

Date of Birth: _____/_____/_____ Phone Number: _____

Name: _____ Relationship to Patient: _____

Date of Birth: _____/_____/_____ Phone Number: _____

New Patient Information

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ SSN: _____-_____-_____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____ Employer Address: _____

Insurance Information

Primary Insurance Provider: _____ Policy Holder's Name: _____

Policy Holder's DOB: _____/_____/_____

Secondary Insurance Provider: _____ Policy Holder's Name: _____

Policy Holder's DOB: _____/_____/_____

Signature: _____ Date: _____

Health History Questionnaire

Name: _____ Date of Birth: _____

Please describe what problem or concern brought you to our office today:

- ☐ Primarily to establish care
- ☐ Other (please briefly describe): _____

Pharmacy (Name and Location) _____

Do you authorize Heritage Urgent & Primary Care to leave health information on your voicemail? ☐ Yes ☐ No

Do you have a Primary Care Provider? ☐ Yes ☐ No If yes: Have you seen the provider in the past year? ☐ Yes ☐ No

Name & Location of Primary Care Provider: _____

Special Communication Needs

Language preference:					
If 'yes' to any of the question below, how can we assist?					
Visual Impairment	☐ Yes	☐ No	Cognitive Impairment	☐ Yes	☐ No
Hearing Impairment	☐ Yes	☐ No	Sensory Impairment	☐ Yes	☐ No
Speech Impairment	☐ Yes	☐ No	Other:		

Personal Health History		Previous Surgical Procedures	
Please check past or current problems or conditions		Check if you have any of the following	
Condition	Condition	Procedure	Year
☐ Hypertension	☐ Seizures	☐ Heart surgery	
☐ High Cholesterol	☐ Headaches	☐ Carotid artery surgery	
☐ Diabetes	☐ Stroke	☐ Vascular surgery / stent	
☐ Heart attack or angina	☐ Prostate problem	☐ Abdominal aneurysm repair	
☐ Irregular heart rhythm	☐ Breast problem	☐ Hysterectomy	
☐ Congestive heart failure	☐ Urinary tract infections	☐ Gallbladder removal	
☐ Asthma	☐ Osteoarthritis	☐ Appendix removal	
☐ Emphysema or chronic bronchitis	☐ Cancer (Please List type)	☐ Tonsillectomy	
☐ Pneumonia	☐ Thyroid problem	☐ Joint replacement	
☐ Gastroesophageal reflux disease	☐ Bleeding disorder	☐ Breast cancer surgery	
☐ Stomach ulcer	☐ Addiction Issues	☐ Prostate cancer surgery	
☐ Kidney problems	☐ Depression or anxiety	☐ Hernia	
☐ Liver disease/Hepatitis	☐ Mental Illness	☐ Pacemaker	
☐ Colon cancer	☐ Other (please describe)	☐ Other (Please describe)	
☐ Bowel/Digestive problem			

Allergies:

Please List any allergies to medications or foods	

Current Health Concerns

Please check problems or conditions that you are CURRENTLY EXPERIENCING			
☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (Please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**FEMALES – PLEASE COMPLETE**
☐ Dizziness / Fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow: ☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Abdominal pain	☐ Headache	☐ Fatigue / Lethargy	
☐ Heartburn	☐ Weakness	☐ Insomnia	Days of flow ___ Length of cycle ___
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period _____
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, Weakness, or Numbness in:		Number of pregnancies _____
☐ Vomiting	☐ Arms	☐ Hips	☐ Back	Miscarriages _____
☐ Vomiting blood	☐ Legs	☐ Neck	☐ Shoulders	Birth control method _____
☐ Change in bowel habits	☐ Hands	☐ Feet	

Medications

Please list all medications that you take including over the counter medications, herbs, and supplements. (Please include dose and frequency)	

Patient Signature: _____ Date: _____