

New Patient Registration

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____
Street City State Zip

Phone # Home: _____ Work: _____ Cellular: _____

Is it ok to leave a detailed message about your medical care? Yes ___ No ___ If yes, circle the # you would prefer we use.

Email _____ May we contact you via email? Yes ___ No ___

Sex ___ M ___ F Age ___ Birth date _____ Single ___ Married ___ Widowed ___ Divorced ___ Separated ___

Employer _____ Occupation _____

In case of emergency who should we notify _____? Phone _____

How did you find out about our office? _____

Primary Insurance

Name of Insured _____
Last Name First Name Initial

Relation to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from Patient) _____
Street City State Zip

Insured Employed by _____ Occupation _____

Bus. Address _____ Bus. Phone _____

Insurance Co _____
Name Address Phone #

Member No _____ Group # _____ Subscriber # _____

Additional Insurance

Is Patient covered by additional insurance? ___ Yes ___ No

Name of Insured _____
Last Name First Name Initial

Relation to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from Patient) _____
Street City State Zip

Insured Employed by _____ Occupation _____

Bus. Address _____ Bus. Phone _____

Insurance Co _____
Name Address Phone #

Member No _____ Group # _____ Subscriber # _____

Assignment and Release

I, _____, certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Mountain Streams Medical Center, PC** all insurance benefits for services received there. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Responsible Party

Date

Patient Name _____

Family Physician

Family Physician _____ Phone # _____

Address _____ Fax # _____

Current Medications

Current Medications,

Supplements , 1. _____ 4. _____

Aspirin Products 2. _____ 5. _____

Or Vitamins 3. _____ 6. _____

Please list any known allergies to medications _____

Please list any other known allergies _____

Health History

Please list any Past Illnesses _____

Please list any Current Illness _____

Please list any Past Surgeries _____

Circle any of the following that applies to you:

- | | | | | |
|--------------------|----------------------|--------------------|------------------------|---------------------|
| Headaches | Breast Lump | Breathing Problems | Hemorrhoids | Family Problems |
| Eye Problems | High Blood Pressure | High Cholesterol | Phlebitis | Sexual Problem |
| Hearing Problems | Arthritis | Heart Trouble | Serious Injury | Sleeping Difficulty |
| Dental/Gum Disease | Gout | Liver Disease | Tuberculosis | Depression |
| Thyroid Disease | Fainting/Convulsions | Stomach Trouble | Rheumatic Fever | Nervousness |
| Diabetes | Abnormal Bleeding | Kidney Disease | Venereal Disease | Stroke |
| Anemia | Hives or Rash | Trouble Urinating | Alcohol /Drug Problems | Other _____ |
| Cancer | Hepatitis | Bowel Trouble | Weight Loss | |

Problems with Varicose Veins or Spider Veins? _____

List Childhood Diseases _____

Hospitalizations: _____

Other Health Issues:

Tobacco use: _____ Age started _____ Amount _____

Caffeine use: _____ How many times per day? _____

Alcohol: _____ How many drinks per week _____

Pregnant? YES NO Maybe (Circle One)

Family Health History

Family History	Alive/Deceased	Age	Family Health Problems- (cause of death)	Do you have any close relatives with
Father				High Cholesterol
Mother				Heart Trouble
Spouse				Cancer (Breast, Prostate, Colon)
Brothers/Sisters				Diabetes
				High Blood Pressure
				Mental Illness
				Thyroid Disease
Children				Bleeding Trouble or Blood Clots
				Hemorrhoids
				Alcohol / Drug Problems
				Alzheimer's

Patient Name _____

Social:

- I am sexually active.
- I want to be sexually active.
- I have completed my family.
- My sex has suffered.
- I haven't been able to have an orgasm.

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Extended Medical History**Preventative Medical Care:**

- Medical/GYN Exam in the last year.
- Mammogram in the last 12 months.
- Bone Density in the last 12 months.
- Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:

- Breast Cancer.
- Uterine Cancer.
- Ovarian Cancer.
- Hysterectomy with removal of ovaries.
- Hysterectomy only.
- Oophorectomy Removal of Ovaries.
- Other cancer (type): _____

Medical Illnesses:

- Blood clot and/or a pulmonary emboli.
- Hemochromatosis.
- Depression/anxiety.
- Psychiatric Disorder.
- Trouble passing urine or take Flomax or Avodart.
- Chronic liver disease (hepatitis, fatty liver, cirrhosis).
- Thyroid disease

Birth Control Method:

- Menopause.
- Hysterectomy.
- Tubal Ligation.
- Birth Control Pills.
- Vasectomy.
- Other: _____