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 form 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____

History Men - BHRT

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletic purposes.

Current Hormone Replacement Therapy: ____

Past Hormone Replacement Therapy: ____

Extended Medical History

Medical Illnesses:

( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Thyroid disease.
( ) Cancer (type): _______________________ Year: ___________

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.
By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

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Print Name **Signature** **Today's Date**