PROVIDENCE Medical Institute

Print | Reset Form

Patient Registration Form Date: ____/____/____ Time: _____

Patient Information

Patient Name:		Soc Sec #:
Sex:	Birth Date:	Aliases:
Street Address: City: State:	ZIP:	Home Phone: Work Phone: Mobile: **How where you referred?** □ Friend/Family □ Another physicians office □ Drive/Walk By □ Website □ Employer/Work □ Flyer/ Advertising □ Other _____
Email:		
Interpreter Needed: □ Yes □ No	Language:	Ethnicity: □ Hispanic □ Non-Hispanic
Marital Status: □ Mar □ Sing □ Wid □ Div □ Sep		Race:

Primary Care Provider Information

PCP:	Phone:	Group:

Emergency Contact

Contact Name:		
Street Address: City: State:	ZIP:	Home Phone: Work Phone: Mobile: Comments:
Email: Relationship to Patient:		Legal Guardian? □ Yes □ No If Yes: Name: Home Phone: Mobile:

Patient's Employer

Employer:		Status: □ Full Time □ Part Time □ Retired □ Disabled □ FT Student □ PT Student □ Not Employed □ Never Employed □ On Active Military Duty
Work Address: City: ZIP:	Employment Date: Phone:	Employee ID: Occupation:

Guarantor Information ☐ Same as patient

Guarantor Name:			Soc Sec #:
Sex:	Birth Date:	Aliases:	
Street Address:		City:	Home Phone:
		ZIP:	Work Phone:
Relationship to Patient:			

Guarantor Employment

Employer: Work Address:		Status: □ Full Time □ Part Time □ Retired □ Disabled □ FT Student □ PT Student □ Not Employed □ Never Employed □ On Active Military Duty
City:	Employment Date:	Employee ID:
ZIP:	Work Phone:	Occupation:

Primary Insurance Info ☐ Same as patient ☐ Same as guarantor

Subscriber Name:			Soc Sec #:
Sex:	Birth Date	Aliases:	
Patient Relationship to Subscriber:		Subscriber ID:	Group #:
Home Address:			City:
			ZIP:
Primary Insurance Company & Plan			

Secondary Insurance Info ☐ Same as patient ☐ Same as guarantor ☐ Same as primary

Subscriber Name:			Soc Sec #:
Sex:	Birth Date:	Aliases:	
Patient Relationship to Subscriber:		Subscriber ID:	Group #:
Home Address:			City: ZIP:
Secondary Insurance Company & Plan:			

Thank you for helping us keep all your important information current!

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NEW PATIENT HEALTH QUESTIONNAIRE FOR ADULTS

Name: _____ **Birth Date:** ____ / ____ / ____ **Date:** ____ / ____ / ____

List all significant illnesses, injuries and hospitalizations (except normal pregnancies):

Asthma	☐	COPD	☐	High Blood Pressure	☐
Cancer	☐	Depression	☐	Heart Attack	☐
Heart Failure	☐	Diabetes Mellitus	☐	Stroke	☐

Other illnesses, injuries and hospitalizations:

_____ _____

_____ _____

List any surgeries or procedures:

Appendectomy	☐	Colon Surgery	☐	Hernia Repair	☐
CABG (Heart)	☐	Eye Surgery	☐	Joint Replacement	☐
Cholecystectomy	☐	Fracture Surgery	☐	Prostate Surgery	☐

Other surgeries and comments:

_____ _____

_____ _____

Dates of last:

Colonoscopy: _____ Pap Smear (women only): _____

Pneumonia Vaccine: _____ Mammogram (women only): _____

FAMILY HISTORY: Enter a "X" or the number of relatives with the condition.

Family History	Cancer	What Type?	Asthma	Depression	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke
Mother									
Father									
Sister									
Brother									
Daughter									
Son									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									

SOCIAL HISTORY:

How many alcoholic drinks per week do you consume? None ___ Glasses of Wine ___ Cans of Beer ___ _Shots of Liquor ___

Are you using any recreational drugs? [ ] NO [ ] YES If yes, what kind?_____

Have you ever smoked or chewed tobacco? [ ] YES [ ] NEVER

If YES, what type of tobacco do (did) you use? [ ] Cigarettes [ ] Cigars [ ] Pipe [ ] Chewing Tobacco / Snuff

If you smoked cigarettes, how many packs per day (20 cigarettes /pack)? _____

How many years have you smoked or chewed tobacco? _____ years

Have you quit using tobacco? [ ] YES [ ] NO If YES, when did you quit using tobacco? _____