Hendricks Regional Health

NEW PATIENT REGISTRATION

Please print the information below and have your insurance card and legal photo ID available for the receptionist to scan.

PATIENT INFORMATION

Social Security #____-____-_____Last Name_____First Name_____Middle____

Address_____City_____St____Zip_____

Home Phone (____)____-_____Work Phone (___)_-_____Ext._____Email:_____

Date of Birth_____Marital Status_____Race_____Sex_Alternate Phone (___)_____-_____

Emergency Contact_____Phone (_____)_____-_____
(Name) (Relationship)

Patient Employer_____Emp. Address_____Emp. Phone (___)_____-_____

Pharmacy most used by patient_____Pharm. Phone (____)____-_____

Referring Provider (Specialist office only) _____

PERSON WHO SHOULD RECEIVE THE BILL - RESPONSIBLE PARTY (Guarantor)

Relationship to Patient: Self Parent Spouse Other _____

Social Security #_____-____-_____Name _____

Address_____City_____St____Zip_____

Home Phone (____)____-_____Work Phone (____)____-_____Ext._____Email:_____

Date of Birth_____Marital Status_____Race_____Sex ___ Alternate Phone (____)_____-_____

Employer_____Emp. Address_____Emp. Phone (____)____-_____

PRIMARY INSURANCE COMPANY NAME_____**No Insurance**
(Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name:_____Date of birth_____SS#_-_-_____

Employer_____PCP_____Copay_____

SECONDARY INSURANCE COMPANY NAME_____

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name:_____Date of birth _____ SS#____-___-_____

Employer_____Copay _____

PLEASE FILL OUT THESE FORMS COMPLETELY AND ACCURATELY. FAILURE TO DO SO MAY RESULT IN A COMPROMISE IN OUR ABILITY TO DELIVER APPROPRIATE CARE.

Name: _____ Date of Birth: _____

Best phone number to contact patient: _____

Pharmacy (Local and/or long term): _____

History of Presenting Illness

Why are you being seen today? _____

How long have you had this problem? _____

What are your current symptoms? _____

Please list the tests you have had done related to this problem: _____

What treatment(s) have you had for this problem? _____

Who is your primary doctor and/or who referred you here? _____

Current Medications (including vitamins, supplements, and herbals); list dosing and frequency taken. Please provide separate list if not enough spaces.

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

Past Medical History-Please include current and past medical problems: _____

_____

_____

_____

Allergies-Please list any medication, food, or environmental allergies that you have. Please include the reaction (ie: rash, nausea, etc.).

_____

_____

_____

Past Surgical History-Please list all procedures that you have had (include surgeries, endoscopies, heart procedures, etc.).

_____

_____

_____

Hospitalizations-Please list reasons and dates.

_____

_____

_____

_____

Family History-Please list any relevant medical conditions in the family and relationship to patient.

_____

_____

Social History

Marital status_____ Occupation_____

Tobacco use-have you ever smoked/chewed? _____ Do you use currently? _____ Packs per day? _____

Alcohol use: _____ How often? _____

Caffeine intake (how much per day):_____ Carbonated beverage intake: _____

Any pets in the home? If so, list: _____

Age of home? _____

Review of systems (fill in the circles that apply)

General

- ◯ Fevers
- ◯ Weight loss
- ◯ Malaise/Fatigue

Skin

- ◯ Rash
- ◯ Itching

Ears, Nose, Throat

Ears:
- ◯ Hearing Loss
- ◯ Ringing (Tinnitus)
- ◯ Ear Pain
- ◯ Ear Discharge

Nose:
- ◯ Nosebleeds
- ◯ Congestion
- ◯ Facial pressure
- ◯ Facial pain
- ◯ Nasal discharge
- ◯ Post-nasal drip

Throat:
- ◯ Sore throat
- ◯ Hoarse voice
- ◯ Trouble swallowing
- ◯ Neck mass / lump

Cardiovascular

- ◯ Chest Pain
- ◯ Palpitations
- ◯ Swelling in feet

Respiratory

- ◯ Cough
- ◯ Shortness of breath
- ◯ Wheezing

Gastrointestinal

- ◯ Heartburn
- ◯ Nausea or vomiting
- ◯ Diarrhea

Eyes

- ◯ Blurred Vision
- ◯ Double Vision

Musculoskeletal

- ◯ Muscle Aches
- ◯ Neck or Back Pain
- ◯ Joint Pain

Endocrine, Hematology, Allergy

- ◯ Easy Bruising / Bleeding
- ◯ Environmental Allergies
- ◯ Thyroid problems

Neurologic

- ◯ Dizziness
- ◯ Headaches
- ◯ Numb or weak

Hendricks Regional Health

At Hendricks Regional Health we take the privacy of your health information seriously. We will not release a patient's health information outside of the allowed exceptions spelled out in our Notice of Privacy Practices without your verbal or written permission.

This form gives you the opportunity to tell us who we can speak to regarding your health information. You are not required to list anyone and you can change who we are permitted speak to at any time by completing a new form.

I authorize Hendricks Regional Health Medical Group physicians and/or staff to speak to the individuals listed below regarding my health and billing information. I understand that I can revoke this authorization at any time by completing a new form.

	Name	Relationship	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

_____ _____
Signature **Date**

_____
Witness

Patient Printed Name _____ Date of Birth _____