Hendricks Regional Health Medical Group
Adult Patient Registration

Please Print Clearly

Date________

Physician ________________________

Patient Information

Name ________________________________

Address ________________________________

City ________________________________

State ________ Zip Code________________

Home Phone________________________

Cell Phone Number ____________________

Work Phone Number ____________________

Date of Birth ___________ Male ☐ Female ☐

Single ☐ Married ☐ SSN__________________

Name of Employer______________________

Emergency Contact ____________________
(**NOT** living with you)

Emergency Contact phone ________________

Relationship to Emergency Contact ________

Primary Insurance ______________________

Secondary Insurance_____________________

Local Pharmacy ________________________
(Please list name and location)

Mail-In Pharmacy ________________________

Email address __________________________

Responsible Party (person who will receive statements)

Name________________________________

Address ______________________________

City _________________________________

State ________ Zip Code ________________

Spouse Information

Name________________________________

Cell Phone Number ____________________

Work Phone Number ____________________

Insured Information
(only provide if other than patient)

Primary Ins: Insured Name ________________

Date of Birth _________ SSN ____________

Relationship to Patient __________________

Secondary Ins: Insured Name ______________

Date of Birth _________ SSN ____________

Relationship to Patient __________________

Additional Information

Race _________________________________

Ethnicity ______________________________
(Options: Hispanic, Non-Hispanic, Refuse to report)

Language ______________________________

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

History of Presenting Illness

Why are you being seen today? ______________________________

How long have you had this problem? ______________________________

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

____

Who is your primary doctor? ____________ **Who referred you here?** ____________

Current Medications: List dosing and frequency taken. Please provide separate list if not enough spaces.

1______________________________

2______________________________

3______________________________

4______________________________

5______________________________

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

____

____

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

____

____

____

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

Mark the following symptoms or conditions that apply to you

General
- ◯ Activity change
- ◯ Appetite change
- ◯ Chills
- ◯ Sweats
- ◯ Fatigue
- ◯ Fever
- ◯ Weight change

Ears, Nose, Throat
- ◯ Congestion
- ◯ Dental problem
- ◯ Drooling
- ◯ Ear discharge
- ◯ Ear pain
- ◯ Facial swelling
- ◯ Hearing loss
- ◯ Mouth sores
- ◯ Nosebleeds
- ◯ Postnasal drip
- ◯ Runny nose
- ◯ Sinus pain
- ◯ Sinus pressure
- ◯ Sneezing
- ◯ Sore throat
- ◯ Ringing in ears
- ◯ Trouble swallowing
- ◯ Voice change

Respiratory
- ◯ Stop breathing
- ◯ Chest tightness
- ◯ Choking
- ◯ Cough
- ◯ Shortness of breath
- ◯ Stridor
- ◯ Wheezing

Cardiovascular
- ◯ Chest pain
- ◯ Leg swelling
- ◯ Palpitations

Gastrointestinal
- ◯ Abdominal swelling
- ◯ Abdominal pain
- ◯ Anal bleeding
- ◯ Blood in stool
- ◯ Constipation
- ◯ Diarrhea
- ◯ Nausea
- ◯ Rectal pain
- ◯ Vomiting

Endocrine
- ◯ Cold intolerance
- ◯ Heat intolerance
- ◯ Excessive thirst
- ◯ Excessive hunger
- ◯ Excessive urination

Musculoskeletal
- ◯ Joint pains
- ◯ Back pain
- ◯ Trouble walking
- ◯ Joint swelling
- ◯ Muscle pains
- ◯ Neck pain
- ◯ Neck stiffness

Allergy / Immune system
- ◯ Allergies to pollen, mold, or pet
- ◯ Food allergies
- ◯ Weakened immune system

Neurological
- ◯ Dizziness
- ◯ Facial weakness
- ◯ Headaches
- ◯ Lightheadedness
- ◯ Numbness
- ◯ Seizures
- ◯ Speech difficulty
- ◯ Passing out
- ◯ Tremor / shakes
- ◯ Weakness

Hematological
- ◯ Large lymph node
- ◯ Bruise/bleed easily

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 ________