MEDICAL REGISTRATION- PATIENT INFORMATION

Today's Date_____

First Name _____Last Name _____Middle Initial _____

Sex : □ M □ F Age _____ Birth date _____Social Security #_____

Address _____City _____State _____ Zip Code _____

Email_____ Phone # (home) _____Cell Phone # _____ Consent to Text Message □ Yes □ No

□ Married □ Single □ Divorced □ Widowed □ Separated □ Partnered

Occupation _____

Patient Employer/ School _____ Employer/ School Phone # _____

Employer/ School Address _____

Spouse's Name _____ DOB _____Spouse's SS # _____

Spouse's Employer _____

How did you hear about us? _____

Emergency Contact Person _____Phone # _____

Is this person able to receive health information about you? □ Yes □ No

INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to Patient _____

DOB _____ SS# _____

Medical Insurance Carrier _____ID# _____Group # _____

Is the patient covered by additional insurance? If yes, please list the name of the Insurance Carrier/ID #/ & Group #

_____

****PLEASE PRESENT ALL INSURANCE CARDS & A VALID PHOTO ID TO THE OFFICE STAFF SO WE CAN COPY & VERIFY YOUR INFORMATION****

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____(Name of Insurance Carrier) and assign directly to Dr. Nguyen/ Valley Family Care, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor/ facility may use my health care information and may disclose such information the above- named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

MEDICARE AUTHORIZATION

Although this office does not accept traditional Medicare, there are certain privately insured plans that are considered Medicare based. I request that payment of authorized benefits and, if applicable, be made wither to me or on my behalf to Dr. Nguyen/ Valley Family Care, P.C. for any services furnished to me by that provider/ facility.

To the extent permitted by law, I authorized any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services, my Medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services.

(Signature of Patient, Parent, Guardian, or Personal Representative)_____

(Print name of Patient, Parent, Guardian, or Personal Representative) _____

FAMILY HISTORY

FATHER □ Alive □ Deceased If deceased, age at time of death _____

Illnesses (Circle all that Apply) Diabetes Heart Disease Cancer Stroke Bleeding Tendency High Blood Pressure
Allergies Kidney Disease Nervous Illness Tuberculosis Other _____

MOTHER □ Alive □ Deceased If deceased, age at time of death _____

Illnesses (Circle all that Apply) Diabetes Heart Disease Cancer Stroke Bleeding Tendency High Blood Pressure
Allergies Kidney Disease Nervous Illness Tuberculosis Other _____

BROTHER(S) □ Alive □ Deceased If deceased, age at time of death _____

Illnesses (Circle all that Apply) Diabetes Heart Disease Cancer Stroke Bleeding Tendency High Blood Pressure
Allergies Kidney Disease Nervous Illness Tuberculosis Other _____

SISTER(S) □ Alive □ Deceased If deceased, age at time of death _____

Illnesses (Circle all that Apply) Diabetes Heart Disease Cancer Stroke Bleeding Tendency High Blood Pressure
Allergies Kidney Disease Nervous Illness Tuberculosis Other _____

CHILDREN □ Alive □ Deceased If deceased, age at time of death _____

Illnesses (Circle all that Apply) Diabetes Heart Disease Cancer Stroke Bleeding Tendency High Blood Pressure
Allergies Kidney Disease Nervous Illness Tuberculosis Other _____

HOW MANY CHILDREN DO YOU HAVE: _____

CIRCLE THE ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

Diabetes Heart Disease Cancer Stroke Bleeding Tendency High Blood Pressure

Allergies Kidney Disease Nervous Illness Tuberculosis Other _____

MEDICAL HISTORY

Date of your last physical exam _____ Are you presently under a physician's care for any condition? □Yes □ No

What is the reason for your visit today? _____

(PLACE A CHECK NEXT TO THE SYMPTOMS YOU HAVE OR HAVE HAD IN THE PAST YEAR)

GENERAL
□ Chills
□ Depression
□ Nervousness
□ Dizziness
□ Fainting
□ Fever
□ forgetfulness
□ Headache
□ Insomnia
□ Weight loss
□ Numbness
□ Sweats

GASTROINTESTINAL
□ Poor Appetite
□ Bloating
□ Bowel changes
□ Constipation
□ Diarrhea
□ Excessive thirst
□ Gas
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Rectal Bleeding
□ Stomach pain
□ Vomiting
□ Vomiting blood

EYE, EAR, NOSE, THROAT
□ Bleeding gums
□ Blurred vision
□ Crossed eyes
□ Double Vision
□ Difficulty swallowing
□ Earache/ear discharge
□ Hay fever
□ Hoarseness
□ Hearing loss
□ Nosebleeds
□ Persistent cough
□ Ringing in ears
□ Sinus problems
□ Vision- flashes/halos

CARDIOVASCULAR
□ Chest pain
□ High Blood Pressure
□ Low Blood Pressure
□ Irregular heart beat
□ Rapid heart beat
□ Poor circulation
□ Swelling of ankles
□ Varicose veins

SKIN
□ Bruise easily
□ Hives
□ Itching/ Rash
□ Change in moles
□ Scars
□ Sore that won't heal

GENITO-URINARY
□ Blood in urine
□ Freq urination
□ Bladder control problems
□ Painful urination

MUSCLE/JOINT/BONE Pain, weakness, numbness in:
□ Arms □ Back □ Feet □ Hands □ Hips
□ Legs □ Neck □ Shoulders

MEN only: □ Erection difficulties □ Lump in testicles □ Penis discharge □ Sore on penis □ Breast lump □ Other

Women only: □ Abnormal Pap smear □ Bleeding between periods □ Breast lump □ Extreme menstrual pain □ Hot flashes □ Nipple discharge
□ Painful intercourse □ Vaginal discharge □ Other

Date of Last menstrual period _____ Date of last pap smear _____ Date of last mammogram_____ Are you pregnant _____

Check conditions that you have or have had in the past

□ AIDS	□ Appendicitis	□ Appendectomy	□ Arthritis	□ Asthma
□ Bleeding disorders	□ Blood transfusion	□ Breast Lump	□ Cancer	□ Car accident with injury
□ Cataracts	□ Chemical dependency	□ Chicken Pox	□ Diabetes	□ Emphysema
□ Epilepsy	□ Glaucoma	□ Heart disease	□ Hepatitis	□ Herpes
□ High Cholesterol	□ HIV positive	□ Kidney disease	□ Liver disease	□ Measles
□ Migraine Headaches	□ Multiple Sclerosis	□ Mumps	□ Pacemaker	□ Pneumonia
□ Polio	□ Port-a-cath	□ Prostate problem	□ Rheumatic fever	□ Scarlet fever
□ Stroke	□ Thyroid problems	□ Tuberculosis	□ Ulcers	□ Venereal disease

MEDICATIONS

List your current medications that you are taking (prescribed and over-the counter)/ Dose/ Frequency

1. _____
2. _____
3. _____
4. _____
5. _____

PHARMACY NAME _____ PHONE # _____

LIST ALLERGIES TO MEDICATIONS/ SUBSTANCES/ ENVIRONMENTAL/ FOOD AND REACTION THAT OCCURS FROM EXPOSURE/ INGESTION

_____

_____

_____

HEALTH HABITS

Caffeine □ occasional □ moderate □ heavy

Street drugs □ occasional □ moderate □ heavy

Tobacco products

smoking do you smoke daily _____ how many _____ for how many years _____
at what age did you start smoking _____
do you want to quit? _____

chew/ snuff do you use this daily _____ for how many years_____
at what age did you start using this product _____
do you want to quit? _____

Alcohol □ occasional □ moderate do you drink every day? _____ How many drinks daily _____
How many drinks weekly _____
Do you have a family history of alcoholism? _____

Stress (home or work) □ minimal □ moderate □ highly stressful

Heavy Lifting (home or work) □ minimal □ moderate □ frequent

Are you exposed to hazardous substances at work? □ Yes □ No **Do you have a gun in your home?** □ Yes □ No

Do you have smoke alarms in your home? □ Yes □ No **Single or Multi-level home? _____Do you wear seatbelts routinely?** □ Yes □ No

Do you use sunscreen? □ Yes □ No

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Patient signature _____ Date _____