Patient Registration Form

Name: ____
Last Name First Name MI (Previous Last name)

SSN #: ______________________ Date of Birth: ______________ Sex: ❏ M ❏ F

Address: ______________________ Home phone: ______________

______________________ Work phone: ______________

______________________ Cell phone: ______________

______________________ Email: ______________

Race: ❏ Caucasian ❏ Hispanic ❏ Bi-racial ❏ African/American ❏ Asian ❏ Other ❏ Decline

Ethnicity: ❏ Hispanic ❏ Non-Hispanic ❏ Decline

Preferred Language: ❏ English ❏ Other______________

Marital Status: ❏ Single ❏ Marrried ❏ Widow ❏ Divored Student Status: ❏ Full Time ❏ Part Time

Referring Physician (if applicable):______________ Phone: ______________

How did you hear about us? (If not referred by physician.) ______________

If we need to leave a message with medical personal information, what number may we use? ______________

Who is your emergency contact? ______________

Relationship: ______________ Phone: ______________

Who is your employer? ______________ Main phone: ______________

Employer's Address: ______________

INSURANCE INFORMATION

Primary Insurance: ______________ Group#: ______________ ID#: ______________

Subscriber: ______________ Relationship to Subscriber: ______________ Effective Date: ______________

Subscriber's Date of Birth: ______________ Subscriber's SSN #: ______________

Secondary Insurance: ______________ Group#: ______________ ID#: ______________

Subscriber: ______________ Relationship to Subscriber: ______________ Effective Date: ______________

Subscriber's Date of Birth: ______________ Subscriber's SSN #: ______________

IF RELATED TO WORK OR INJURY

Type ❏ Worker's Comp ❏ Auto Accident ❏ Legal/Employer ❏ Personal Injury ❏ Other Claim #: ______________

Date of Injury or Accident: ______________ State of Injury/Accident: ______________

Worker's Comp/Auto Accident Insurance Carrier: ______________ Phone: ______________

Address: ______________ City: ______________ State: ________ Zip Code: ________

Case Contact Person: ______________ Phone: ______________

Attorney Practice Name: ______________ Phone: ______________

Address: ______________ City: ______________ State: ________ Zip Code: ________

Medical History

Name: ______________________________

Address: ______________________________

____

____

Marital Status: ❏ Married ❏ Divorced ❏ Widowed ❏ Separated

If married, spouse's name:

____

Children's names and ages

______________________________ Age________

______________________________ Age________

______________________________ Age________

______________________________ Age________

Sex: ❏ M ❏ F Date of Birth: ____________ Age: ______

Home phone: ______________________________

Work phone: ______________________________

Cell phone: ______________________________

Your Occupation: ______________________________

SSN #: ______________________________

Emergency contact information

Name: ______________________________

Phone: ______________________________

Referred by: ______________________________

Allergies to Medications, X-Ray Dyes, or Other Substances: ❏ Yes ❏ No

If yes, please list name of medication/substance and type of reaction:

Medication/Substance	Reaction
______________________	______________________
______________________	______________________
______________________	______________________

Past Medical History & Review of Symptoms: (Please circle if you have any problems or are presently complaining of any of the following.)

High blood pressure	Lightheadedness	Hay fever	Ulcers	Head or neck radiation	Blood disorders
Diabetes	Frequent urination	Abdominal discomfort	Change in bowel habits	Headache	Venereal diseases
Cancer	Rheumatic fever	Indigestion	Unexplained weight gain/loss	Kidney diseases	Anxiety
Heart disease	Asthma	Nausea	Hemorrhoids	Kidney stones	Depression
Chest pain/chest tightness	Bronchitis	Vomiting	Gall bladder disease	Difficulty urinating	Anemia
Shortness of breath	Pneumonia	Constipation	Colitis	Arthritis	Alcohol abuse
Swollen ankles	Persistent cough	Diarrhea	Hepatitis or jaundice	Low back problems	Drug abuse
Palpitations	T.B.	Blood in stool	Thyroid disease	Skin diseases	Gout

Gynecologic and Obstetric History:

Age at onset of periods: ________________ Frequency: ________________ Length of period: ____________

Pregnancies: ______________ Births: __________ Miscarriages: __________

Prolonged or abnormal bleeding: ❏ Yes ❏ No Please describe: ______________________________

Leakage of urine: ❏ Yes ❏ No Please describe: ______________________________

Pelvic pain: ❏ Yes ❏ No Please describe: ______________________________

Abnormal discharge: ❏ Yes ❏ No Please describe: ______________________________

History of abnormal pap smear: ❏ Yes ❏ No Type of treatment: ______________________________

Please list and provide dates for the following:

Operations: ____________________ ____________________ ____________________

____________________ ____________________ ____________________

Hospitalizations other than for surgery: ____________________ ____________________

____________________ ____________________

____________________ ____________________

Immunization History – Have you had:

Hepatitis B	❑ Yes	❑ No	When? ____________
Pneumovax Immunization	❑ Yes	❑ No	When? ____________
Flu Immunization	❑ Yes	❑ No	When? ____________
Tetanus Immunization	❑ Yes	❑ No	When? ____________
Other____________	❑ Yes	❑ No	When? ____________

When was your last:

Pap smear: ____________

Mammogram: ____________

Breast exam: ____________

Cholesterol Check: ____________

Stool check for blood: ____________

Prostate exam: ____________

Family History:

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed:
Cancer (describe type)	____________	____________
Hypertension (high blood pressure)	____________	____________
Diabetes	____________	____________
Strokes	____________	____________
Mental disease (anxiety, depression etc.)	____________	____________
Drug or alcohol addiction	____________	____________
Glaucoma	____________	____________
Bleeding disorders	____________	____________
Other: ____________	____________	____________

Medications: (Prescriptions, over-the-counter, vitamins, herbs, etc.)

Drug	Dose	Drug	Dose
____________	______	____________	______
____________	______	____________	______
____________	______	____________	______
____________	______	____________	______
____________	______	____________	______
____________	______	____________	______
____________	______	____________	______

Prevention:

Do you wear a seatbelt? ❑ Yes ❑ No If no, why not? ______________________________

Do you wear a bike helmet? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No If yes, how many packs per day? ______________________________

Do you drink alcoholic beverages? ❑ Yes ❑ No If yes, how much per week? ______________________________

Do you drink coffee? ❑ Yes ❑ No If yes, how many cups per day? ______________________________

Do you drink tea? ❑ Yes ❑ No If yes, how many cups per day? ______________________________

If there is a gun in your home, is it out of children's reach and unloaded? ❑ Yes ❑ No

Do you use drugs? (marijuana, cocaine, crack, etc.) ❑ Yes ❑ No If yes, explain: ______________________________

____

Have you ever engaged in any activity which has put you at risk of getting AIDS? ❑ Yes ❑ No If yes, explain: ______________________________

____

Do you wish to be tested for AIDS? ❑ Yes ❑ No

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? If yes, explain: ______________________________

____

Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, punched, bruised) by your partner? ❑ Yes ❑ No

Do you ever feel afraid of your partner? ❑ Yes ❑ No

Do you have a "living will"? ❑ Yes ❑ No

Do you have a donor card? ❑ Yes ❑ No

Method of birth control? ______________________________

*****I hereby authorize Dr. Karmazin to release any medical information that may be necessary for either medical care or my insurance company.*****

Signature: ______________________________

ACKNOWLEDGEMENT OF RECEIPT FORM

Health Insurance Portability and Accountability Act, [HIPAA]

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name ____ **Date of Birth:** _____________
(Please Print)

By signing below, I acknowledge receipt of or the opportunity to review the Notice of Privacy Practices of South Jersey Holistic. In addition, by signing below, I authorize South Jersey Holistic to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

Signature: ____ **Date:** ____________________

Phone Authorization

_____Yes, you have my permission to leave medical information on my answering machine. Please let us know which daytime telephone number is best to do so.

( ) _______________________________.

_______No, you do not have my permission to leave medical information on my answering machine.

To whom, other than yourself, may we speak regarding your medical condition?

Name _______________________________________ **Relationship** _____________________

Phone# _________________________

Name _______________________________________ **Relationship** _____________________

Phone# _________________________

I have the right to withdraw or revise my permission at any time in writing.

Signature: ____ **Date:** ____________________

For Office Use Only:

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

_______ Individual refused to sign.

_______ An emergency situation prevented us from obtaining the acknowledgement.

Signature of South Jersey Holistic Representative: ____