PATIENT REGISTRATION INFORMATION

Please PRINT and complete ALL sections below!

PATIENT Name: ______________________ Last ______________________ First ______ M.I.

Birthdate: ____________ Age: ______ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: ____________ City: ____________ State: ______ Zip: ______

Home Phone: ( ) ____________ Cell Phone: ( ) ____________

email: ____________

Social Security: ____________ Driver's License (State & Number): ____________

Employer: ____________ Work Phone: ( ) ____________

Medical Reason for Visit: ____________

Referred By: ____________ Primary Physician ____________

Date of Onset/Injury: ____________ Work-Related Injury? ☐ Yes ☐ No

Spouse Name: ____________ Work Phone: ( ) ____________

Emergency Contact: ____________ Phone: ( ) ____________

PARENT/GUARDIAN Name: ____________ Birthdate: ____________

Social Security: ____________ Relationship to Patient: ☐ spouse ☐ parent ☐ other:

Employer: ____________ Work Phone: ( ) ____________

INSURANCE INFORMATION *Please complete ALL insurance information. A copy of your insurance card is required.*

Primary Insurance: ____________	Secondary Insurance: ____________
Ins. Address: ____________	Ins. Address: ____________
City: ______ State: ______ Zip: ______	City: ______ State: ______ Zip: ______
Name of Insured: ____________	Name of Insured ____________
Employer: ____________	Employer ____________
Insured ID: ______ SSN: ______	ID Number ____________
Group Number: ____________	Group Number: ____________
Rel. to Patient: ☐ self ☐ spouse ☐ parent ☐ other ______	Rel. to Patient: ☐ self ☐ spouse ☐ parent ☐ other ______
Insured's Birth Date: ____________	Insured's Birth Date: ____________

I DIRECTLY ASSIGN ALL MEDICAL/SURGICAL BENEFITS TO DR. ALAVI (MY PHYSICIAN), AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE MY PHYSICIAN TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS, FURTHERMORE, I AUTHORIZE MY PHYSICIAN, OR HIS REPRESENTATIVES, TO OBTAIN COPIES OF ANY AND/OR ALL CLINICAL RECORDS RELEVANT TO THE PURSUIT OF THE ISSUE(S) FOR WHICH I AM BEING SEEN IN THIS OFFICE. I UNDERSTAND THAT ALL RETURNED CHECKS MAY BE SUBJECT TO A SERVICE CHARGE AND THAT I MAY BE RESPONSIBLE FOR OTHER COSTS OF COLLECTION AS PERMITTED BY LAW. I UNDERSTAND THAT, ULTIMATELY, THE PRESENCE OR ABSENCE OF INSURANCE APPROVAL FOR THE SAME WITH MY SIGNATURE BELOW. I GIVE MY GENERAL CONSENT TO RECEIVE SUCH TREATMENT AND/OR DIAGNOSTIC MEASURES THAT MAY BE DEEMED NECESSARY BY MY PHYSICIAN.

I ACKNOWLEDE THAT I HAVE READ AND UNDERSTAND THE ABOVE.

Method of payment: ☐ cash ☐ check ☐ credit card

Signature of Responsible Party: ____________ Date: ____________

Medical History Questionnaire

Circle all applicable medical conditions

Y N

❑ ❑ **Constitutional**: fever, sweats, chills, shakes, unexpected weight loss, fatigue, cancer, other ______

❑ ❑ **Visual**: glaucoma, cataracts, double vision, other ______

❑ ❑ **Ear, Nose and Throat**: (*other than what you are being seen for today*) ______

❑ ❑ **Cardiovascular**: chest pain, heart attack, high blood pressure, valve problems, exercise intolerance, cholesterol, other ______

❑ ❑ **Respiratory**: asthma, emphysema, shortness of breath, TB, other ______

❑ ❑ **Gastrointestinal**: acid reflux, ulcers, hepatitis, gallstones, bowel obstruction, constipation, diarrhea, blood in the stool, other ______

❑ ❑ **Genitourinary**: burning/difficulty urinating, blood in the urine, stones, other ______

❑ ❑ **Musculoskeletal**: polio, broken bones, other ______

❑ ❑ **Skin**: skin cancers, changing pigmented areas, rash, other ______

❑ ❑ **Neurologic**: strokes, seizures, migraines, numbness, tingling, , other ______

❑ ❑ **Psychiatric**: depression, bipolar disorder, anxiety, insomnia, other ______

❑ ❑ **Endocrine**: diabetes, pituitary, thyroid, steroid usage, other ______

❑ ❑ **Hematologic**: easy bleeding/bruising, platelet problems, hemophilia, other ______

❑ ❑ **Previous surgeries**: (type and date): ______

❑ ❑ **Major Medical**: chemotherapy, radiation treatments, other ______

➢ **Family history** (circle): Father Alive & Well Age: ____ Deceased (cause): ______

Mother Alive & Well Age: ____ Deceased (cause): ______

Siblings: ______

❑ ❑ **Allergic problems**: hives, rash, food, environmental, latex, other ______

❑ ❑ **Current medications** (please list): ______

❑ ❑ **Medical allergies** (please list): ______

Do you...use **tobacco**? Y / N / Quit, __ average packs/day, for how many years? ______ use **recreational drugs**? Y / N

drink **alcohol**? Y / N, how much? ______ drink **coffee/tea/sodas**? Y / N , how much? ______

May we have permission to leave messages on your cell-phone, home answering machine and/or personal voice mail?Y / N

Name (please print): ______ Date: ______

Reviewed (initials, date)...