NEW PATIENT REGISTRATION

PATIENT INFORMATION

Last Name ______________________________ First Name ____________________________ Middle ______________________Suffix_________

Name you go by ________________________ Date of Birth: ______________________ Email ____

Age __________ Primary phone (home / work / cell): (_______) ___________________ Alternate (home / work / cell): (_______) _______________

Address: ____ Apt/Unit #: ______________

City: ____ State: __________ Zip: __________________________ Gender: Male Female

Social Security Number ____ Marital Status: Single Married Divorced Widowed

RESPONSIBLE PARTY (GUARANTOR) INFORMATION (if different from patient)

Last Name _______________________________ First Name _______________________________ Middle _______________________________

Date of Birth: ____________________________ Email ____

Primary phone (home / work / cell): (_______) __________________________ Alternate (home / work / cell): (_______) ______________________

Address: ____ Apt/Unit #: ___________

City: ____ State: __________ Zip: __________________________

Social Security Number _______________________________ Relationship to Patient: Spouse Parent Guardian Other ____________________

INSURANCE COMPANY INFORMATION (please present card at check-in)

Primary Insurance Company: ____ Address: ____

City: _______________________ State: _____ Zip: ___________ Name of insured: __________________________________Date of Birth________

Relationship to patient: Self Spouse Child Other Policy #: _______________________ Group #: _______________________ Copay: $__________

Secondary Insurance Company: ______________________________________ Address: ____

City: _______________________ State: _____ Zip: ___________ Name of insured: __________________________________Date of Birth________

Relationship to patient: Self Spouse Child Other Policy #: _______________________ Group #: _______________________ Copay: $__________

REFERRAL INFORMATION

How did you hear about us? Friend ___ Insurance Directory ___ Direct Mail Card ___ Newspaper/magazine (title)___________________________

Or if referred by a health care professional, who may we thank for referring you to us?____

Is your visit due to a job related injury or automobile accident? _____If yes, please notify us at check-in

YOUR PREFERRED PHARMACY FOR PRESCRIPTIONS

Pharmacy Name: ___________________________________ Phone ______________________________ Fax _______________________________

Address: ____ City: ______________________________ State: ______ Zip: ___________________

EMERGENCY CONTACT

Name: ________________________________ Best Phone #: (_____) __________________ Relationship to Patient: Self Spouse Parent Other:

ASSIGNMENT OF BENEFITS • GUARANTY OF PAYMENT

I hereby give authorization for payment of insurance benefits arising from services rendered by Diabevita Medical Center (DMC) to be made directly to DMC. I understand that I am financially responsible for all charges incurred by the above patient whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections including reasonable attorney's fees. I hereby authorize DMC to release all information necessary to secure the payment of benefits from my insurance company. I further agree that a photocopy or facsimile of this agreement shall be as valid as the original.

Signed ____ Date ____________________

NEW PATIENT PERSONAL HEALTH HISTORY

Full Name ______________________ Today's Date ______________________

Name you go by ______________________ Date of Birth ______________________

Your answers on this form will help our doctors and staff better understand your medical concerns and conditions. You do not have to answer all questions, but be aware that not answering completely could lead to misdiagnosis or inappropriate treatment recommendations. If you cannot remember specific details, please provide your best guess. All information is held confidential pursuant to our Privacy Policies.

Main reason for today's visit: ______________________

Other concerns you would like to discuss: ______________________

TELL US WHAT MEDICATIONS YOU ARE CURRENTLY TAKING: (Including prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.) Continue on back if more space is needed.

Medication	Dose (e.g., mg/pill)	How many times per day

What medications cause you allergies: ______________________ Reaction: ______________________

SCREENING TESTS: Please check any you've had done in past 5 years.

Test		When?	Results
Blood sugar	______	When? ______	Results ______
Cholesterol	______	When? ______	Results ______
PSA (prostate)	______	When? ______	Results ______
Triglycerides	______	When? ______	Results ______
Diabetes Hba1C	______	When? ______	Results ______
Urine protein	______	When? ______	Results ______
Colonoscopy	______	When? ______	Results ______
Mammogram	______	When? ______	Results ______
Pap smear	______	When? ______	Results ______
Osteoporosis	______	When? ______	Results ______

NAME ______________________

SURGICAL HISTORY: Please list all prior surgeries you have had (with year):

____

____

____

HOSPITALIZATION HISTORY: Please list all in-patient hospital stays (for other than listed surgeries), the dates and the reason

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PERSONAL MEDICAL HISTORY: Please **circle** any listed medical condition you have now or have had in the past. Please explain with comments.

- Allergies ______________
- Heart problems (what kind) ______________
- Asthma/COPD ______________
- Prostate problems ______________
- Stroke ______________
- Gallstones ______________
- Cancer (specify type) ______________
- Diabetes ______________
- Broken bones ______________
- Heartburn/ulcers ______________
- Headaches/migraines/tension ______________
- High cholesterol/triglycerides ______________
- High blood pressure ______________
- Thyroid problem ______________
- Anemia ______________
- Arthritis/Osteoporosis ______________
- Urinary Tract Infections ______________
- Kidney stones ______________

FAMILY MEDICAL HISTORY: Please **circle** and write in on each line which family member **-** a parent, sibling, grandparent, aunt or uncle **-** have had the listed medical condition.

	Who?
Heart disease/attack	
Bleeding / clotting disorder	
High cholesterol	
High blood pressure	
Sudden death	
Cancer, specify type	
Asthma / COPD / TB	
Stomach/Intestinal problems	
Kidney Stones / kidney disease	
Dementia	
Migraines	
Seizures	
Stroke	
Diabetes	
Thyroid problem	
Anemia / blood disorder	
Arthritis	
Gout	
Allergies	
Depression / suicide	
Mental Illness	
Alcoholism or drug abuse	

NAME ______________________________

DIABETES HISTORY. If you have been diagnosed with diabetes or told you have pre-diabetes, please answer these questions.

When were you diagnosed? ______________________________

When and how often do you check your blood sugar? ______________________________

How many diabetes education classes have you attended? ______________________________

Have you had diabetes nutritional counseling? ______________________________

When was your last test, and the results for these tests:

Hemoglobin A1C ______________________________
Urine Protein ______________________________
Cholesterol ______________________________
Triglycerides ______________________________
EKG ______________________________
Eye Exam by an Opthalmologist ______________________________
Foot Exam ______________________________

LIFESTYLE QUESTIONS:

Occupation: ______________________________
Employer: ______________________________
Years of education/highest degree: ______________________________

Marital Status: Single / Partner / Married / Divorced / Widowed
Spouse / partner's name: ______________________________
Number of children/ages: ______________________________
Who lives at home with you? ______________________________

What kind of exercise do you do?______________________________
How long (minutes) / how many days a week?__________________

Do you wear a helmet when you ride a bike, motorcycle or skate board? No ___Yes ___ N/A ___

What are your hobbies /recreation ______________________________

Cigarettes:
Never Smoked ________________ Quit Date __________________
Current Smoker: packs/day ____________ # of years ____________
Other Tobacco: Pipe _____ Cigar _____ Snuff _____ Chew ____
Are you interested in quitting? No _______ Yes _______

Do you drink alcohol? No _____Yes ______ # drinks/week ______

Birth control method: ____________________None needed _____
Do you have sex with: Men ______ Women ______ Both ______

How many cups of Coffee or tea per day do you drink
____

How many glasses of soda ____________________________
Do you drink regular or diet soda? ____________________________

Are you satisfied with your weight? No ____ Yes ____
How do you rate your diet? Good ___ Fair ___ Poor ____

Is violence at home a concern for you? No ____ Yes ____
Have you ever been abused? No ____ Yes ____

Have you completed a living will or durable power of attorney for health care? No ____ Yes ____

NAME ________________________________

YOUR IMMUNIZATIONS: Please list the year you last had each of these immunization shots:

Influenza (flu shot) - when? ________

Pneumonia shot - when? ________

Tetanus (Td) - when? ________

Tdap (tetanus & pertussis) - when? ________

Varicella (chicken pox or shingles) shot - when? ________

Hepatitis A - when? ________

Hepatitis - when? ________

Meningitis - when? ________

WOMEN'S HEALTH HISTORY:

First day of your most recent period ______________________________

pregnancies _______ # deliveries _____ # abortions ______ # miscarriages _______

Age at start of periods: ___________ Age at end of periods:____________

ANY OTHER COMMENTS / CONCERNS TO ADDRESS WITH DR. HILTS:

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