Print Form

A. WISE M.D.
FAMILY MEDICINE

{PATIENT REGISTRATION FORM}

PERSONAL INFORMATION

FIRST NAME _____
LAST NAME _____
ADDRESS _____
CITY _____
ZIP CODE _____
HOME PHONE _____
CELL PHONE _____
WORK PHONE _____
EMAIL _____
GENDER _____
PRIMARY LANGUAGE _____
RESPONSIBLE PARTY _____
RELATIONSHIP _____

SSN _____
DATE OF BIRTH _____
MARITAL STATUS _____
OCCUPATION _____
EMPLOYER _____

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, NOTIFY _____
RELATIONSHIP _____
ADDRESS _____
CITY _____
ZIP CODE _____
HOME PHONE _____
WORK PHONE _____
CELL PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME _____
SUBSCRIBER'S NAME _____
SUBSCRIBER'S DOB _____
GROUP# _____
SECONDARY INSURANCE NAME _____
SUBSCRIBER'S NAME _____
SUBSCRIBER'S DOB _____
GROUP# _____

TEL _____
SUBSCRIBER'S SSN _____
MEMBER ID# _____
BILLING ADDRESS _____
TEL _____
SUBSCRIBER'S SSN _____
MEMBER ID# _____
BILLING ADDRESS _____

I request that payment of insurance benefits be made, on my behalf, to Alphaeus Wise, M.D., for any services furnished by said physician. I authorize any holder of medical information needed to determine these benefits payable to related services. For Medicare, the physician agrees to accept assignment, and I am only responsible for deductibles, co-insurance, and any non-covered services. I understand that in all other cases, I am financially responsible for the payment of any and all charges incurred with Alphaeus Wise, M.D. I authorize Alphaeus Wise, M.D., to furnish information to insurance carriers concerning my diagnosis and treatments.

_____

Signature (Patient or Guardian)

Date

MEDICAL HISTORY RECORD

Name _____ **Date of Birth:** ___/___/_____

MEDICINES YOU ARE TAKING List prescription medicines, birth control pills, over-the-counter medicines, injections, herbal medicines, and vitamins that you are taking.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ALLERGIES List any drugs, medications, or allergens to which you are allergic.

1. _____ Please list allergic reaction here: _____
2. _____ Please list allergic reaction here: _____
3. _____ Please list allergic reaction here: _____
4. _____ Please list allergic reaction here: _____

HOSPITALIZATIONS List serious illnesses and injuries requiring hospitalization.

Year	Serious illness or injury	Name of Hospital	City and State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SURGERIES List any past surgeries, including gynecological procedures and C-sections.

Year	Name of Surgery	Name of Hospital	City and State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OTHER PAST MEDICAL HISTORY

List any medical problems not mentioned above.

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

PREGNANCY HISTORY

Enter the number of:

Times pregnant _____

Live births_____ Living children_____

Abortions_____ Miscarriages_____

Complications? ☐Yes ☐No

History of chickenpox infection: Yes No

HEALTH CARE PROVIDERS Who else have you seen for your health care in the past 7 years?

Year	Name of doctor or other provider	Location (City, State)	Primary Problems Cared For
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name _____

WORK HISTORY Are you working now? ☐YES ☐No, I'm out of work ☐No, I'm retired ☐No, I've never had a job
Starting with your most recent job, what type of work have you done?

	Type of Work or Job Title	Dates From	To
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

SMOKING HISTORY

Do you smoke or use tobacco now? ☐**YES** ☐**NO** If yes, how much? _____ packs per day for _____ years
If you quit smoking/using tobacco, when was it? _____ (date that you quit)
How much did you smoke/use before you quit? _____ packs per day for _____ years

ALCOHOL AND DRUG HISTORY

How much alcohol do you drink, if any? _____ drinks per week
If you no longer drink alcohol, when did you quit? _____
Have you ever used other "recreational" drugs? ☐**YES** ☐**NO**
If yes, which drugs and when? _____
If you no longer use "recreational" drugs, when did you quit? _____

EXERCISE HISTORY

Do you exercise? ☐**YES** ☐**NO** If yes, how much do you exercise per week? _____
What activities do you include in your exercise regimen? _____

YOUR FAMILY'S HEALTH

	First Name	Health is: Good	Poor	Died at	Age	Medical Problems and/or Cause of Death
Father	_____	☐	☐	☐	_____	_____
Mother	_____	☐	☐	☐	_____	_____
Paternal Grandfather	_____	☐	☐	☐	_____	_____
Paternal Grandmother	_____	☐	☐	☐	_____	_____
Maternal Grandfather	_____	☐	☐	☐	_____	_____
Maternal Grandmother	_____	☐	☐	☐	_____	_____
Brothers and sisters	_____	☐	☐	☐	_____	_____
	_____	☐	☐	☐	_____	_____
	_____	☐	☐	☐	_____	_____
	_____	☐	☐	☐	_____	_____
	_____	☐	☐	☐	_____	_____
Spouse	_____	☐	☐	☐	_____	_____
Children	_____	☐	☐	☐	_____	_____
	_____	☐	☐	☐	_____	_____
	_____	☐	☐	☐	_____	_____
	_____	☐	☐	☐	_____	_____
Others living in household	_____	☐	☐	☐	_____	_____

Check any illnesses where members of your family have had the following illnesses or problems:

☐ Alcoholism	☐ Diabetes	☐ Heart disease	☐ Liver disease	☐ Cancer, tumor
☐ Anemia	☐ Drug abuse	☐ Heart attack	☐ Mental illness	☐ Breast cancer
☐ Asthma	☐ Epilepsy	☐ High blood pressure	☐ Stroke	☐ Lung cancer
☐ Deep vein thrombosis	☐ Eye problems	☐ Lung disease	☐ Suicide attempt	☐ Colon cancer

☐ Depression ☐ Glaucoma ☐ Kidney disease ☐ Thyroid disease ☐ Other _____