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 _____