

REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Today’s Date:** | | | | | | | **REFFERED BY:** | | | | | | | | | | | | | |
| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| **Last Name: First: Middle:** | | | | | | | | | * Mr. * Mrs. * Miss. * Ms. | | | **Marital Status:** Single Mar  Div  Sep Wid | | | | | | | | |
| **Social Security #:** | | | | | | | | |
| **RACE/ETHNICTY:** CAUCASIAN, BLACK, HISPANIC, ASIAN, NATIVE AMERICAN, OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **LANGUAGE:** ENGLISH, SPANISH,  OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | **BIRTH DATE:** | | | | | | | **AGE:** | | | **SEX:**   M  F |
| **Street Address:** | | | | | | | | **City:** | | | | | | **State:** | | | | | | **Zipcode:** |
| **Home Phone #:** | **Cell Phone #:** | | | | | | | | | | | | **Work #:** | | | | | | | |
| **Email Address:** | | | | | | | | | | | | | | | | | | | | |
| **Occupation:** | **Employer:** | | | | | | | | | | | | **Employer Phone #:** | | | | | | | |
| **Preferred Pharmacy:** | | | **Address:** | | | | | | | | | | | **Ph:** | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| **Primary Insurance Company:** | | | | | | **Member ID:** | | | | | | | | | **Grp #:** | | | | | |
| **Insured Name:** | | **Birth Date:** | | | | **Address (if different)** | | | | | | | | | | | | | **Relationship:** | |
| **Secondary Insurance Company:** | | | | | | **Member ID:** | | | | | | | | | | **Grp #:** | | | | |
| **Insured Name:** | | **Birth Date:** | | | | **Address (if different)** | | | | | | | | | | | | | **Relationship:** | |
| **MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | | |
| **REASON FOR TODAY’S VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PAST MEDICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PAST SURGERIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ALLERGIES: (Drugs, Food, Latex)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **MEDICATIONS: (Dosage, Regimen)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **FAMILY MEDICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | |
| **SOCIAL HISTORY** | | | | | | | | | | | | | | | | | | | | |
| **LIVES WITH:** Alone Family  Roommate  Partner*List*:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **EXERCISE:** Yes No *Type*/*Amount*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **TOBACCO:** Never Current *How often*: \_\_\_\_\_\_\_\_\_\_\_  Past Use *Quit date* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DRUG USE:** Never Current *How often*: \_\_\_\_\_\_\_\_\_\_\_ *Type:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ALCOHOL:** Never Current: Occasional, Moderate, Heavy Past Use | | | | | | | | | | | | | | | | | | | | |
| **IN CASE OF EMERGENCY** | | | | | | | | | | | | | | | | | | | | |
| **Name of friend or relative:** | | | | | **Relationship:** | | | | | | **Home/Cell Ph#:** | | | | | | | **Work Ph #:** | | |
| By signing this form, I give my consent to be treated by the medical providers of this practice. I allow the providers and staff of **BETHEL** to give me the needed medical treatment and services they recommend. I understand treatment and services may include: lab tests, screening tests, diagnostic tests, and routine exams.  I understand that no promises have been made to me about the results of any treatment or any treatment or service. The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the practice. I understand I am financially responsible for any balance. I also authorize my insurance company to release any information required to process to my claims.  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | |