

Eastside Medical Group
Patient Registration Form

PATIENT INFORMATION

(Please Print)

Dr. Mr. Mrs. Ms. Jr./Sr.

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

E-Mail Address: _____

Date of Birth MM ____/DD ____/YYYY _____ Sex F – Female M - Male Transgender

Social Security Number ____ - ____ - ____

Race/Ethnicity Asian Black or African American Caucasian Hispanic or Latino
 American Indian/Alaska Native Native Hawaiian/Other Pacific Islander Declined

Language English Spanish Other _____

Marital Status Married Single Divorced Widowed Legally Separated Partner

Primary Care Provider (PCP) _____ Referring Provider _____

Pharmacy _____ Pharmacy Phone _____

Employer Name _____ Employer Phone _____

Employment Status 1 - Full-Time 2 - Part-Time 3 - Not Employed 4 - Self-Employed 5 - Retired 6 - Active
Military

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Relationship to Patient _____

Do you have a living will? Yes No

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Self

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Date of Birth MM ____/DD ____/YYYY _____ Sex F – Female M - Male

Social Security Number ____ - ____ - ____ Telephone _____

E-Mail Address _____

(If different from patient) Address _____ City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Primary Insurance _____ Insured _____ DOB _____

Secondary Insurance _____ Insured _____ DOB _____

How did you hear about us?

Website Internet Search Internet Advertisement Family/Friends Facebook Magazine/Newspaper Ad
 Another healthcare provider: _____ Physician Directory Hospital MD Referral – Medline

Eastside Medical Group:

DATE: _____

Name: _____ Date of Birth: _____ Age: _____

Male / Female (circle one)

Pregnant Yes / No (circle one)

Reason you are here: _____

SOCIAL HISTORY

Marital Status: Single Married Partner Divorced Widow/Widower
Children _____ Occupation/Job _____ Religion _____

HABITS

Do you dip or chew tobacco? Yes No If yes, how much per day? _____

Smoking:

Never smoked Former smoker Date Quit _____ Current smoker / How Long? _____ Packs per day? _____

Do you drink alcoholic beverages? If yes, how many per week? _____

Do you drink beverages that contain caffeine: (coffee, tea, soda) _____ cups per day

Do you use recreational drugs? If yes, what and how often? _____

CURRENT MEDICATIONS:

Include herbal and over-the-counter drugs. List and name dose. Using additional sheet if needed.

(If you brought a medication list or brought your medications DO NOT FILL OUT)

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

MEDICATION ALLERGIES:

No medication allergies

Are you allergic to latex? Yes No

PAST MEDICAL HISTORY

Please check below if you have, or have had any of the following medical conditions

No Past medical problems

- Acid reflux
- Adverse reaction to anesthesia
- Alzheimer's significant memory loss
- Anemia
- Angina or chest pain
- Arthritis
- Asthma
- Atrial fibrillation or erratic heartbeat
- Bleeding problems
- Blood transfusion
- Blood clot in leg(s) or lung(s)
- Bruise easily
- Cancer Type: _____
- Thyroid Disease
- Other not listed, explain: _____

- Congestive heart failure
- Dental disease
- Depression
- Diabetes
- Emphysema
- Epilepsy/Seizures
- Fibromyalgia
- Gallbladder disease
- Gout
- Heart disease
- Hemophilia / Excessive bleeding
- Hepatitis
- High blood pressure / Hypertension
- High cholesterol
- Tuberculosis

- HIV or Aids
- Infections: _____
- Kidney/Bladder disease
- Leg pain
- Lung disease
- Osteoporosis
- Peripheral vascular disease
- Pneumonia
- Psychiatric disorder
- Rheumatoid arthritis
- Sickle cell
- Sleep apnea / CPAP machine
- Stroke

FAMILY HISTORY

Please check below if Mother, Father, Siblings have had any of the following: No family medical history to report

	Who		Who
<input type="checkbox"/> Adverse reaction to anesthesia	_____	<input type="checkbox"/> Blood clots/Pulmonary embolism	_____
<input type="checkbox"/> Bleeding disorders	_____	<input type="checkbox"/> Cancer Type & Age	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Rheumatoid Arthritis	_____
<input type="checkbox"/> Heart Disease (age at first event)	_____	<input type="checkbox"/> Stroke (age at first event)	_____
<input type="checkbox"/> Hypertension	_____		

SURGICAL HISTORY

Please check below if you have had any of these surgeries

No Previous Surgeries

	Year		Year		Year
<input type="checkbox"/> Aneurysm – Abdominal	_____	<input type="checkbox"/> Colon surgery	_____	<input type="checkbox"/> Open heart surgery	_____
<input type="checkbox"/> Angioplasty / stents	_____	<input type="checkbox"/> Fistula R or L	_____	<input type="checkbox"/> Pacemaker/Defibrillator	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Gallbladder	_____	<input type="checkbox"/> Prostate surgery	_____
<input type="checkbox"/> Artery bypass of arm/ leg	_____	<input type="checkbox"/> Gastric bypass surgery	_____	<input type="checkbox"/> Spine surgery	_____
<input type="checkbox"/> Breast surgery	_____	<input type="checkbox"/> Heart stents	_____	<input type="checkbox"/> Tonsils	_____
<input type="checkbox"/> Caesarean section	_____	<input type="checkbox"/> Hernia surgery where	_____	<input type="checkbox"/> Total hip / knee	_____
<input type="checkbox"/> Carotid surgery	_____	<input type="checkbox"/> Hysterectomy	_____	<input type="checkbox"/> Other not listed,	
<input type="checkbox"/> Cataract surgery	_____	<input type="checkbox"/> Nasal surgery	_____	explain: _____	

HOSPITALIZATIONS

No Past Hospitalizations

Date: (Mo/Yr)	Reason
_____	_____
_____	_____
_____	_____

GYN HISTORY

<input type="checkbox"/> LMB	_____	Year		<input type="checkbox"/> Last PAP Smear (date)	_____
<input type="checkbox"/> Last Mammogram (date)	_____			<input type="checkbox"/> Last Dexascan (date)	_____
<input type="checkbox"/> Hx of Abnormal PAP smear		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> STD	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> Birth Control	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

To Be Filled Out By Nurse

Review of symptoms negative

HEIGHT: _____ WEIGHT: _____ TEMP: _____ PULSE: _____ O2 SAT: _____

BP RIGHT ARM: _____ BP LEFT ARM: _____

FLU SHOT: _____ Date: _____

Diagnosis _____