[Aaron Stone MD]

REGISTRATION FORM

PATIENT INFORMATION

Today's Date: PCP:

☐ Mr. ☐ Mrs. ☐ Miss | Social Security # Driver's License #

Birth date: Age: Sex: ◯ M ◯ F ◯ O

Patient's last name: First Name] Middle: [Initial] | Email Address

Home Address: City State Zip Code

Home phone no.: Work Phone: Cell phone no.:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Minor

Employer | Occupation: | Employer phone no.:

Work Address City State Zip

Spouse/Parent : Occupation

Last Name First Name Middle Initial

Employed By Work Phone

Work Address Work City Work State Zip

Who to notify in an emergency Phone

Who referred you to this office?

MEDICAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

How do you intend to pay? ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ Medicare

Name of Insurance Company: | ID #

Address City State Zip

Policy Number | Group Name /#

Reason for this visit ☐ Illness ☐ Injury ☐ Job Related Injury ☐ Auto Accident ☐ Personal Injury

Date of Injury or Onset of Problem | Major Complaint

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION

Name of Responsible Party

Address City State Zip

Relationship to the patient Social Security Number

Employed By Work Phone Home Phone

IF YOUR INJURY IS JOB RELATED

Name of Person Who Can Authorize Treatment

Company's Insurance Carrier

Address City State Zip

Insurance Carrier Phone Number OK'D BY

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, have insurance coverage with _____ and assign directly to

Name of Insurance Carrier

_____ all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand

Name of Doctor

that I am financial responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for any balance.

_____ _____

Patient/Guardian signature Date

HEALTH QUESTIONNAIRE

Name_____**Age**_____**Date**_____

Address_____**Phone**_____

HISTORY OF PAST ILLNESS: Check if you have had

Childhood

- ☐ Measles
- ☐ Mumps
- ☐ Chickenpox
- ☐ Diabetes
- ☐ Strokes
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Veneral disease
- ☐ Rheumatic fever or heart disease
- ☐ Congenital Abnormalities
- ☐ Other serious diseases

_____

Adult

☐ **Have you had any serious illness**_____

☐ **Have you ever been hospitalized or been under medical treatment for very long**_____

If yes, for what reason_____

Operations

☐ **Have you ever had surgery**_____

List_____

_____

_____

Injuries

☐ **Have you had any broken bones**_____

☐ **Have you had any head concussions or injuries**_____

☐ **Have you ever been knocked unconscious**_____

Family History	If Living: Age	Health	If Deceased Age(at death) & cause		Has any blood relative ever had:	
Father					Cancer	☐
Mother					Tuberculosis	☐
Brother/Sister					Diabetes	☐
					Heart Trouble	☐
					Stroke	☐
					Convulsions	☐
Husband/Wife					Suicide	☐
Son/Daughter					Mental Illness	☐
					Bleeding tendency	☐
					Gout or other arthritis	☐
					Hereditary defects	☐

Social History

Marital Status ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Are you living with your husband or wife_____ ☐ **YES** ☐ **NO**

Do you have dependents at home_____ ☐ **YES** ☐ **NO**

Alcoholic Beverages ☐ **Never** ☐ **Rarely** ☐ **Moderately** ☐ **Daily** **Every** _____

Tobacco ☐ **Cigarettes** _____ **Packs a day** ☐ **Don't Smoke** ☐ **Never Smoked**

Are you employed **Full time**_____ **Part time**_____

What is your job_____

Are you exposed to fumes, dust or solvents_____

How much time have you lost form work because of health during the past:

6 months_____ **year**_____ **5 years**_____

Education (years)

Grade school _____ **College**_____ **Postgraduate**_____

CHECKLIST: Review of Systems

General-

- ☐ Recent weight change
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin-

- ☐ Skin Disease
- ☐ Jaundice
- ☐ Hives, eczema or rash
- ☐ Frequent infection or boils
- ☐ Color changes, abnormal pigmentation
- ☐ Hair and nail changes

Head-Eyes-Ears-Nose-Throat

- ☐ Eye disease or injury
- ☐ Do you wear glasses or contacts
- ☐ Double vision, vision loss/ changes, blurry vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Headaches
- ☐ Itching eyes or nose
- ☐ Sneezing or runny nose
- ☐ Nose bleeds
- ☐ Chronic sinus trouble
- ☐ Ear disease
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Ear Drainage
- ☐ Hay fever
- ☐ Sinus pain
- ☐ Dentures
- ☐ Sore tongue
- ☐ Yellow eyes
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Non-healing sores

Neck-

- ☐ Thyroid trouble
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Breasts-

- ☐ Lumps
- ☐ Pain
- ☐ Discharge

Respiratory-

- ☐ Chronic or frequent cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma or Wheezing
- ☐ Painful or difficult breathing
- ☐ Pleurisy or Pneumonia

Cardiovascular-

- ☐ Chest pain, angina or discomfort
- ☐ Heart Palpitations or Murmur
- ☐ Shortness of breath with walking or lying down
- ☐ Difficulty walking 2 blocks
- ☐ High blood pressure
- ☐ Swelling of hands, feet or ankles
- ☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal-

- ☐ Peptic ulcer (stomach or duodenal)
- ☐ Vomiting blood or food
- ☐ Does food stick in throat
- ☐ Gallbladder disease
- ☐ Liver trouble
- ☐ Hepatitis
- ☐ Painful bowel movements
- ☐ Bleeding with bowel movements
- ☐ Black stools
- ☐ Hemorrhoids or piles
- ☐ Swallowing difficulties
- ☐ Heartburn or indigestion
- ☐ Change in appetite
- ☐ Nausea
- ☐ Recent change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation

Urinary-

- ☐ Frequent urination
- ☐ Night time urinating
- ☐ Urgency
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Kidney trouble
- ☐ Kidney stones
- ☐ Incontinence
- ☐ Change in urinary strength

Vascular-

- ☐ Calf pain with walking
- ☐ Leg cramping
- ☐ Varicose veins

Musculoskeletal-

- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Neurologic-

- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor
- ☐ Paralysis

Hematologic-

- ☐ Abnormal bleeding or bruising
- ☐ Excessive bleeding after surgery or dental work
- ☐ Anemia
- ☐ Phlebitis

Endocrine-

- ☐ Heat or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite
- ☐ Hormone therapy
- ☐ Diabetes
- ☐ Thyroid disease

Psychiatric-

- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss
- ☐ Have you seen or been advised to see a psychiatrist

Gynecological-

Age periods started_____
How long periods lasted_____days
Number of pregnancies_____
Number of miscarriages_____
Date of last cancer smear and results_____
Is there a chance you are pregnant ☐ No ☐ Yes
Frequency of periods every _____days
Number of children_____ Ages_____
Date of last period _____

HEIGHT_____ WEIGHT_____

ALLERGIES AND SENSITIVITIES:

1. Is there a history of skin reaction or other untoward reaction of sickness following an injection or oral administration of:

Penicillin or other antibiotics	No
Morphine, Codeine, Demerol or other narcotics	No
Novocaine or other anesthetics	No
Aspirin, empirin or other pain remedies Sulfa drugs	No
Tetanus antitoxin or other serums	No
Adhesive tape	No
Iodine or merthiolate	No
Any other drug or medication	No
Any foods such as egg, milk or chocolate	No

What drug or food?_____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

2. Drugs recently taken with the past 6 months

Cortisone	No
ACTH	No
Anticoagulants	No
Tranquilizers	No
Hypotensives (high blood pressure medicines)	No
Any treatment for Asthma, rheumatism or rheumatic fever	No
Aspirin	No

Source of information, if other than patient_____

Signature of person acquiring this information_____

_____Aaron Stone MD_____ _____ _____
Doctor Date Signature of patient

Submit By Email