BEAVER/MILFORD/PAROWAN MEDICAL CLINICS

FAMILY REGISTRATION

Submit Via Email

HEAD OF HOUSEHOLD - RESPONSIBLE PARTY

NAME: _____ DATE OF BIRTH: _____ AGE: _____
FIRST MIDDLE INITIAL LAST

RACE: __ WHITE
__ BLACK / AFRICAN AMERICAN
__ HISPANIC / LATINO
__ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER
__ MORE THAN ONE RACE

GENDER: MALE_____ FEMALE_____
SOCIAL SECURITY NUMBER: _____
PREFERRED LANGUAGE: _____
PREFERRED PHARMACY: _____

HOME ADDRESS: _____ _____
PO BOX STREET ADDRESS CITY STATE ZIP

HOME PHONE: _____ CELL PHONE: _____
EMPLOYER: _____ OCCUPATION: _____
WORK ADDRESS: _____ WORK PHONE: _____
MARITAL STATUS: _____ DRIVERS LICENSE NUMBER: _____
RESPONSIBLE PARTY EMAIL ADDRESS: _____
SPOUSE'S NAME: _____ SPOUSES DATE OF BIRTH: _____
SPOUSE'S EMPLOYER: _____ SPOUSE'S WORK PHONE: _____

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ AGE: _____
FIRST MIDDLE INITIAL LAST

RACE: __ WHITE
__ BLACK / AFRICAN AMERICAN
__ HISPANIC / LATINO
__ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER
__ MORE THAN ONE RACE

GENDER: MALE _____ FEMALE _____
SOCIAL SECURITY NUMBER: _____
PREFERRED LANGUAGE: _____
PREFERRED PHARMACY: _____

HOME ADDRESS: _____ _____
PO BOX STREET ADDRESS CITY ZIP

HOME PHONE: _____ _____

METHOD OF PAYMENT

PAYMENT WILL BE MADE BY:

CASH( ) CHECK ( ) CREDIT CARD: VISA ( ) MASTERCARD ( ) DISCOVER ( )

INSURANCE INFORMATION

INSURANCE #1: _____ WHO IS POLICY HOLDER: _____
ADDRESS: _____
GROUP NUMBER: _____ POLICY NUMBER: _____
INSURANCE #2 _____ WHO IS POLICY HOLDER: _____
ADDRESS: _____
GROUP NUMBER: _____ POLICY NUMBER: _____

WHO CAN WE CONTACT IN CASE OF EMERGENCY (FRIEND OR RELATIVE NOT LIVING WITH YOU):

NAME: _____ PHONE NUMBER: _____
ADDRESS: _____ RELATIONSHIP: _____

ASSIGNMENT OF BENEFITS: I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plan to Beaver Medical Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance, including reasonable attorney's fees, court costs, filing fees, including charges or commissions that may be assessed to us by any collection agency retained to pursue collection of the balance owed, which may be as much as 50% of the principle balance owed. I/We further agree to pay interest at the rate of 1 1/2% per month (18% APR) pre and post judgment. I hereby authorize said assignee to release all information necessary to secure payment or to provide medical care.

SIGNED _____ DATE _____

(01-2011)

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PATIENT MEDICAL HISTORY FORM

ALLERGIES:
(List all allergies)

ROUTINE MEDICATIONS:
(List all prescription and over the counter medications you are taking)

MEDICAL HISTORY

Past	Current/Ongoing	
❑	❑	Asthma
❑	❑	Back Pain
❑	❑	Bronchitis
❑	❑	Chest Pains
❑	❑	Depression
❑	❑	Diabetes
❑	❑	Gallbladder trouble
❑	❑	Heart Burn
❑	❑	Heart Murmur
❑	❑	Heavy/Irregular Menses
❑	❑	Hemorrhoids
❑	❑	Hernia
❑	❑	High Blood Pressure
❑	❑	High Cholesterol
❑	❑	Insomnia
❑	❑	Kidney Stones
❑	❑	Melena
❑	❑	Miscarriage
❑	❑	Mononucleosis
❑	❑	Pacemaker
❑	❑	Pneumonia
❑	❑	Prostate Problems
❑	❑	Seasonal Allergies
❑	❑	Seizures
❑	❑	Sexual Dysfunction
❑	❑	Sinusitis
❑	❑	Stroke
❑	❑	Thyroid Problems
❑	❑	Ulcers
❑	❑	Urinary Problems

Family Medical History

Father ❑ Alive ❑ Deceased at age _____

Mother ❑ Alive ❑ Deceased at age _____

	Father	Mother	Sibling	Grandparent
Arthritis	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Cancer	❑	❑	❑	❑
Gout	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑
High Cholesterol	❑	❑	❑	❑
Liver Disease	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑
Stroke	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑
Prostate Cancer	❑	❑	❑	❑
Cervical Cancer	❑	❑	❑	❑
Uterine Cancer	❑	❑	❑	❑
Ovarian Cancer	❑	❑	❑	❑
Lung Cancer	❑	❑	❑	❑
Liver Cancer	❑	❑	❑	❑
Bone Cancer	❑	❑	❑	❑
Brain Cancer	❑	❑	❑	❑

Past Immunizations (adults only):

Hepatitis A – Date: _____

Hepatitis B – Date: _____

Influenza Vaccination – Date: _____

Pneumonia Vaccination – Date: _____

Tetanus – Date: _____

TB Booster – Date:

SOCIAL HISTORY

Tobacco Use:
- ❑ No
- ❑ Quit, how long not smoking? _____
- ❑ Yes, how long? _____ ____packs/week

Alcohol Use:
- ❑ No
- ❑ Yes. How often? _____

Illicit drug use: ❑ Never
- ❑ Yes. List: _____

Occupation: _____

Exercise:
- ❑ Yes
- ❑ No

Caffeine Use:
- ❑ Yes Cups per day:_____
- ❑ No

Are you or others concerned about your safety and would like to discuss it: Yes _____ No _____

Do you want a living will put in your chart? Yes _____ No _____