

BEAVER/MILFORD/PAROWAN MEDICAL CLINICS

FAMILY REGISTRATION

HEAD OF HOUSEHOLD - RESPONSIBLE PARTY					
NAME: _____		DATE OF BIRTH: _____		AGE: _____	
FIRST	MIDDLE INITIAL	LAST			
RACE: <input type="checkbox"/> WHITE			GENDER: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		
<input type="checkbox"/> BLACK / AFRICAN AMERICAN			SOCIAL SECURITY NUMBER: _____		
<input type="checkbox"/> HISPANIC / LATINO			PREFERRED LANGUAGE: _____		
<input type="checkbox"/> NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER			PREFERRED PHARMACY: _____		
<input type="checkbox"/> MORE THAN ONE RACE					
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: <input type="checkbox"/> WHITE			GENDER: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		
<input type="checkbox"/> BLACK / AFRICAN AMERICAN			SOCIAL SECURITY NUMBER: _____		
<input type="checkbox"/> HISPANIC / LATINO			PREFERRED LANGUAGE: _____		
<input type="checkbox"/> NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER			PREFERRED PHARMACY: _____		
<input type="checkbox"/> MORE THAN ONE RACE					
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		Family Medical History
<input type="checkbox"/>	<input type="checkbox"/> Asthma	Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased at age _____
<input type="checkbox"/>	<input type="checkbox"/> Back Pain	Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased at age _____
<input type="checkbox"/>	<input type="checkbox"/> Bronchitis		<u>Father</u> <u>Mother</u> <u>Sibling</u> <u>Grandparent</u>
<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	Arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Depression	Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Gallbladder trouble	Gout	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Heart Burn	Heart Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Heart Murmur	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Heavy/Irregular Menses	High Cholesterol	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Hemorrhoids	Liver Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Hernia	Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol	Stroke	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Insomnia	Breast Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	Colon Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Melena	Prostate Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Miscarriage	Cervical Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Mononucleosis	Uterine Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Pacemaker	Ovarian Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Pneumonia	Lung Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	Liver Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Seasonal Allergies	Bone Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Seizures	Brain Cancer	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Sexual Dysfunction	<u>Past Immunizations (adults only):</u>	
<input type="checkbox"/>	<input type="checkbox"/> Sinusitis	Hepatitis A – Date: _____	
<input type="checkbox"/>	<input type="checkbox"/> Stroke	Hepatitis B – Date: _____	
<input type="checkbox"/>	<input type="checkbox"/> Thyroid Problems	Influenza Vaccination – Date: _____	
<input type="checkbox"/>	<input type="checkbox"/> Ulcers	Pneumonia Vaccination – Date: _____	
<input type="checkbox"/>	<input type="checkbox"/> Urinary Problems	Tetanus – Date: _____	
		TB Booster – Date: _____	

SOCIAL HISTORY

<p>Tobacco Use:</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Quit, how long not smoking? _____</p> <p><input type="checkbox"/> Yes, how long? _____ packs/week</p> <p>Alcohol Use:</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes. How often? _____</p> <p>Illicit drug use: <input type="checkbox"/> Never</p> <p><input type="checkbox"/> Yes. List: _____</p>	<p>Occupation: _____</p> <p>Exercise:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>Caffeine Use:</p> <p><input type="checkbox"/> Yes Cups per day: _____</p> <p><input type="checkbox"/> No</p>
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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 _____