Affiliates of Family Medicine
REGISTRATION FORM

(Please Print)

Today's Date	Date of First Office Visit

PATIENT INFORMATION

Patient's Last Name	First	MI	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth _____/_____/_____	Social Security # _____-_____-_____	Driver's License #
Preferred Language	Race	Ethnicity

Spouse's Last Name	First	MI	Social Security #	Date of Birth:
Responsible Party's Last Name	First	MI	Social Security #	Date of Birth:

Street Address	Home Phone	Cell Phone

City	State	Zip Code	Email Address

Occupation	Employer Name & Address	Employer's Phone

How did you hear about us? ☐ Dr. ☐ Insurance Plan ☐ Hospital ☐ Family Friend ☐ Close to Work/Home ☐Other

Name of Pharmacy	Pharmacy Phone #	Name of other family members seen here

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to Patient	Phone #	Alternate Phone #

NOTICE & CONSENT

You have the right, as a patient, to be informed about your condition(s) and the recommended medical treatment(s) to be used so that you may make the decision whether or not to undergo the treatment(s) or procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the treatment.

- I voluntarily request _____ as my provider, and such associates, technical assistants and other health care providers as they may deem necessary, to render primary healthcare services.
- I voluntarily consent to and authorize my healthcare services to be rendered by the above-named healthcare provider.
- I understand my provider may discover other or different conditions which require additional or different procedures than those planned. I authorize my provider, and such associates, technical assistants and other health care providers to perform such other treatment or procedures which are advisable in their professional judgment.
- I understand no warranty or guarantee has been made to me as to the results of my treatment or cure.
- I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.
- I have been given, or I will be given, an opportunity to ask questions about my condition(s), procedure(s) to be used, or treatment to be provided, and the risks and hazards involved. I believe I have sufficient information to give informed consent.

Patient/Guardian Signature Date

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Affiliates of Family Medicine. I understand that I am financially responsible for any balance. I also authorize Affiliates of Family Medicine to release any information required to process my claims

Patient/Guardian Signature Date

Affiliates of Family Medicine

Health Assessment Form Page 1

Please fill out to the best of your ability

Are you allergic to any medications? ☐ Yes ☐ No **If answer is yes, please describe below:**

Medication Name	Describe the reaction (i.e. hives, rash, etc.)

Please list all medications you are currently taking (please include over-the-counter, supplements & contraceptives):

Medication Name	Strength/Dosage	Frequency	Reason Why?

PAST MEDICAL HISTORY: Please indicate if you have been diagnosed with any illnesses below by checking the box.

Illness	✓	Date of Diagnosis	Illness	✓	Date of Diagnosis
AIDS or HIV			Hepatitis (type _____)		
Anemia			High Blood Pressure		
Alcoholism			High Cholesterol		
Allergies (not medication)			Hernia		
Anorexia / Bulimia			Kidney Disease / Failure		
Appendicitis			Liver Disease		
Arthritis			Lung Disease		
Asthma			Measles		
Cancer (type_____)			Migraines		
Chemical Dependency			Mononucleosis		
Chicken Pox			Mumps		
Cataract			Pneumonia		
Depression			Psychiatric Care		
Diabetes			Rheumatic Fever		
Esophageal Reflux			Rubella		
Emphysema / COPD			Ovarian Cysts		
Epilepsy / Convulsions			Stomach Ulcer		
Frequent Kidney/Bladder Infections			Sexually Transmitted Disease		
Frequent Lung Infection			Stroke / Min Stroke		
Gallbladder Disease / Gallstones			Thyroid Problems (type_____)		
Glaucoma / Eye Disease			Tonsillitis		
Gout			Tuberculosis		
Heart Disease			Whooping Cough		

SURGICAL HISTORY: Please list any other operations, hospitalizations, or procedures you have had with date (MM/YY)

Surgery/Hospitalization	Date	Please Describe	Surgery/Hospitalization	Date	Please Describe

Signature of Patient or Guardian_____ **Date**_____

Affiliates of Family Medicine

Health Assessment Form Page 1

Please fill out to the best of your ability

FAMILY HISTORY: Please indicate if your blood relatives have had any of the following

Illness	Relation	Illness	Relation
AIDS or HIV		Glaucoma / Eye Disease	
Arthritis		Heart Disease	
Asthma		High Blood Pressure	
Bleeding Disorder		Kidney Disease	
Bowel Disease		Lung Disease	
Epilepsy / Convulsions		Psychiatric Care	
Chemical Dependency		Stroke	
Depression		Thyroid Problems	
Diabetes		Tuberculosis	
Cancer (type _____)		Other ?	

SOCIAL HABITS: Have you used any of the following?

Substance	Check One	Amount Per Day?	For How Long?	When Stopped?
Alcohol	☐ Yes ☐ No			
Tobacco Products	☐ Yes ☐ No			
Caffeine	☐ Yes ☐ No			
Street Drugs (type _____)	☐ Yes ☐ No			

Are you sexually active? ☐ Yes ☐ No **How many partners have you had in the last year?**_____

Do you exercise safe sex precautions? ☐ Yes ☐ No **Would you like info on safe sex precautions?** ☐ Yes ☐ No

PREVENTATIVE: Please indicate the last time you had the following test/vaccine (MM/YY). Please note some are age dependent.

Exam	Date	Result?	Vaccine	Date
Cholesterol Testing			Tetanus/Diptheria/Whooping Cough Booser	
Eye Exam with Dilation			Flu Vaccine	
Colonoscopy			Hepatitis B Vaccine	
Tuberculosis Testing			Pneumonia Vaccine	
Stool Occult Blood Testing			Shingles Vaccine	
Males Only: Prostrate Exam			HPV Vaccine	
Males Only: PSA Level				

FEMALE PATIENTS ONLY - GYNECOLOGICAL HISTORY: Please answer the below questions if they are applicable for you.

Test / Exam	Date	Results	Performed By?
Pap Smear			
Clinical Breast Exam			
Mammogram			
Osteoporosis DEXA Scan			
STD and HPV Testing			

Age of onset of menstrual cycle _____ **Are they regular each month?** ☐ Yes ☐ No

Age of onset of menopause _____ **Hysterectomy?** ☐ Yes ☐ No **Have you taken estrogen therapy?** ☐ Yes ☐ No

Preferred Method of Contraception? _____ **Have you ever had an IUD?** ☐ Yes ☐ No

Tubal Ligation? ☐ Yes ☐ No **Number of Pregnancies** _____ **Number of Live Births** _____ **C-Section** ☐ Yes ☐ No

Have you had any miscarriage or complications with pregnancies or deliveries? ☐ Yes ☐ No

If yes, please explain:_____

Signature of Patient or Guardian_____ **Date**_____