



Patient Registration

PATIENT REGISTRATION

Reason for visit _____ Work Related Yes No
 Patient Name _____ Social Security No. _____ Sex: M F
 Mailing Address _____ Date of Birth _____
 City/State _____ Zip _____ Tel No. _____
 How did you hear about us? _____ Marital Status: S M W SEP D
 Family Physician _____
 Consent to send records to Family Physician Yes No

PATIENT'S/RESPONSIBLE PARTY'S EMPLOYER INFORMATION

Name _____ Occupation _____
 Employer Name _____ Work Ph# _____ Cell Phone _____
 Employer Street Address _____ City/State _____ Zip _____

RESPONSIBLE PARTY'S INFORMATION

Name _____ Social Security No. _____ Sex: M F
 Mailing Address _____ City/State _____ Zip _____
 Home Tel No. _____ Work Tel No. _____ Cell No. _____
 Relationship to patient _____

PERSON TO CONTACT IN CASE OF EMERGENCY (Other than parent)

Name _____ Relationship _____
 Home Phone _____ Work Phone _____ Cell Phone _____

INSURANCE

#1 Primary Insurance Co. Name _____ ID # _____ Plan _____ Group _____
 Subscriber's Name _____ Relationship _____ Subscriber's Employer _____
 DOB _____ SSN# _____
#2 Secondary Insurance Co. Name _____ ID # _____ Plan _____ Group _____
 Subscriber's Name _____ Relationship _____ Subscriber's Employer _____
 DOB _____ SSN# _____

CONSENT FOR TREATMENT, ASSIGNMENT & RELEASE

I hereby consent to treatment by Acute Care E-Town, PLLC, I have read and acknowledge their Privacy Policies. I hereby authorize the release of any IHI (individually identifiable health information) required for my treatment or in the processing of this claim. I also authorize my insurance benefits to be paid directly to Acute Care E-Town, PLLC. I am financially responsible for non-covered services, deductibles, copays and co-insurance.

Signature: _____ Date: _____
 Patient or Responsible Party

Office Use Only
Clerk: _____
LVD: _____

Medical History Form

Family History: Do any relatives (parents, grandparents, brothers, sisters) have any of the following illnesses? Please check "Yes" or "No"

Heart problems/ murmurs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Relationship to you: _____
Allergy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Relationship to you: _____
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Relationship to you: _____
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Relationship to you: _____
Blood Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Relationship to you: _____

Past Medical History: Do you have any of the following illnesses? Please check "Yes" or "No"

None	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hypertension (high blood pressure)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Respiratory problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Neurological problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Seasonal allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bleeding disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Thyroid problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney/bladder problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stomach or intestinal problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Social History:	Yes	No	Are you allergic to any medications Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you smoke? How much?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list: _____
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How often? _____			_____

Surgeries: Yes No If yes, please list

Current Medications: Yes No If yes, please list

Review of Systems

Please check the "Yes" or "No" box to indicate if you have any of the following symptoms.

GENERAL	YES	NO	ALLERGY	YES	NO	NEURO	YES	NO	HEENT	YES	NO	
Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>	Environmental	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss/ringing	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>				Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	
						Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	
									Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	
RESPIRATORY	YES	NO	CARDIAC	YES	NO	GASTROINTESTINAL	YES	NO	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Nasal drainage	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>				
Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>				Heartburn/indigestion	<input type="checkbox"/>	<input type="checkbox"/>	URINARY	YES	NO	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>				Diarrhea/ constipation	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	
									Burning	<input type="checkbox"/>	<input type="checkbox"/>	
BLOOD/LYMPH	YES	NO	MUS/SKELETAL	YES	NO	SKIN	YES	NO	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Joint aches/pain	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>				
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Muscle aches/pain	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE	YES	NO	
Bleeding/bruising	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance: heat/cold	<input type="checkbox"/>	<input type="checkbox"/>	
									Changes in skin/hair	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER - Please explain												
										PSYCH	YES	NO
										Depression	<input type="checkbox"/>	<input type="checkbox"/>
										Anxiety/panic	<input type="checkbox"/>	<input type="checkbox"/>

(Office use) Reviewed by:

Date: