Patient Registration

Legal Name: _____ Date of Birth: _____-_____-_____ SS#: _____-_____-_____

Preferred Name: _____ Preferred Language: _____Sex ___Male ____Female

Address: _____City: _____ State: _____ Zip Code: _____

Pharmacy: _____ Email: _____

Home Phone: (_____)-_____-_____ Cell Phone: (_____)-_____-_____

Preference for appointment reminders: Consent to call? (circle) YES or NO Consent to Text? (circle) YES or NO

May we leave a message on answering machine concerning:

Results of Tests (circle): YES or NO Appointments (circle): YES or NO

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

Ethnicity: ☐ Non-Hispanic ☐ Mexican, Mexican American, Chicano/a ☐Puerto Rican ☐ Cuban ☐Other:_____ ☐ Choose not to disclose

Race: ☐ White ☐ Black/ African American ☐Asian Indian ☐Chinese ☐Filipino ☐ Japanese☐Korean☐ Vietnamese☐ Other Asian ☐Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ American Indian/ Alaska Native ☐ Samoan ☐ More than one race ☐ Other: _____☐ Choose not to disclose

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Why do we ask lifestyle questions? Because we treat uninsured and underinsured patients, we are required to report certain demographics on ALL patients. Reported information will not contain your name, address, or social security number. Blank answers will be noted as declined.

Please check any which apply

Are you a Veteran? ☐ Yes ☐No **Are you Homeless?** ☐ Yes ☐ No **Agricultural Worker:** ☐Yes ☐No

Public housing patient: ☐ Yes ☐No

What is your current family size? (living in household) _____

What is your current household estimated income? (please list yearly amount) $_____

How did you hear about us? _____

ALLIANCE FAMILY HEALTH CENTER

Insurance Information

Primary Insurance Name_____
Member ID# _____Group# _____
Policyholder Name: _____ Policyholder DOB: _____
Policyholder SSN#_____-_____-_____Policyholder employer: _____
Patient's relationship to Policyholder: ☐ Self ☐Spouse ☐Dependent
Secondary Insurance Name: _____
Member ID# _____Group# _____
Policyholder Name: _____ Policyholder DOB: _____
Policyholder SSN#_____-_____-_____Policyholder employer: _____
Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐Dependent

EMERGENCY CONTACT INFORMATION: Please give the name and phone number or a responsible person that you give permission for our office to contact in case of emergency.

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

RELEASE OF INFORMATION: Please give the name and phone number of a responsible person that you authorize to use, receive, and/or disclose your protected health information.

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

I am authorizing treatment for the above patient. This treatment may include administration of medications, diagnostic testing, and x-ray examination, or other treatment as deemed necessary by the attending physician. I authorize the release of any medical of other information as necessary to process claims on my behalf. I authorize my insurance benefits (included authorized Medicare benefits, If applicable) be paid directly to Alliance Family Health Center (AFHC) for any services furnished. To provide continuity of care, I authorize the release of medical information to specialty physicians under contract with AFHC. I understand that I am responsible for all co-pays, deductibles, and co-insurance. Furthermore, if I am not eligible for insurance, I am responsible for full payment of services rendered. I acknowledge that I have been notified that the Notice of Privacy Practices of AFHC, which sets forth the ways in which my protected health information may be used or disclosed by AFHC and outlines my rights with respect to such information. I have been provided the opportunity to request a paper copy of this notice as well as information on how to view the notice electronically on the website at www.alliancefamilyhealth.org. I give permission for AFHC Physicians to obtain my medical history, benefits, and formulary information from my pharmacy on file.

_____ _____
Patient signature Date

_____ _____ _____
Parent/guardian signature Date Relationship to patient

Patient Past Medical History

Please check each which apply to the patient:

Acid Reflux (GERD)		Breast problems		Kidney Disease	
Addiction		Cancer		Liver Disease	
ADHD		Coronary Artery Disease (CAD)		Lung Disease	
AIDS/HIV		Depression		Mental/Emotional problems	
Anemia		Diabetes		Abuse(mental,physical,verbal)	
Anxiety		Eating Disorder		Muscle, joint, bone problem	
Asthma		GI Problems		Osteoporosis	
Autoimmune Disease		Headache/ Migraine		Seizures or Epilepsy	
Birth defect/inherited disease		Heart Problems		Skin Problems	
Bladder problems		Hepatitis		Thyroid problems	
Bleeding disorder		High Blood Pressure		Tuberculosis	
Blood transfusions		High Cholesterol		Vision/ eye problems	
Other:					

Has the patient ever had any surgeries or hospitalizations? ☐YES ☐NO

If yes, please list surgeries with the year or the date and location of hospitalizations:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Does the patient have any allergies to medications, substances, or food? ☐ Yes ☐NO

If yes, please list allergies:

_____

_____

Current Medications

Medication Name	Dose	Who prescribed Medication?	Medication name	Dose	Who prescribed medication?

Family Medical History

Please list any immediate family medical history
(example: Cancer, diabetes, high blood pressure)

	Medical History		Medical History
Mother		Father	
Sibling(s)		Child	
Maternal Grandmother		Paternal Grandmother	
Maternal Grandfather		Paternal Grandfather	
Maternal Aunt(s)		Paternal Aunt(s)	
Maternal Uncle(s)		Paternal Uncle(s)	

Health Habits

Does the patient use tobacco products? ☐**YES** ☐**NO** if yes, *how much per day?*_____
Does the patient drink alcohol? ☐**YES** ☐**NO** *if yes, how many drinks per week?*_____
Does the patient use any illegal substances? ☐**YES** ☐**NO** *if yes, what kind and how often?*_____
Does the patient consume caffeine? ☐**YES** ☐**NO** *What kind and how often?* _____

Screenings

Have you ever had a screening mammogram? ☐ YES ☐ NO **Approximate date:** _____ **Result:** _____

Facility where it was done: _____

Have you ever had a colonoscopy/Cologuard? ☐ YES ☐ NO **Approximate date:** _____ **Result:** _____

Facility where it was done: _____

Have you ever had a DEXA (bone density) scan? ☐ YES ☐ NO **Approximate date:** _____ **Result:** _____

Facility where it was done: _____

Have you ever had a Low Dose Lung CAT Scan? ☐ YES ☐ NO **Approximate date:** _____ **Result:** _____

Facility where it was done: _____

Have you ever been tested for HIV? ☐ YES ☐NO **If Yes, Approximate Year**_____ **Result:** _____

GYN AND SEXUAL HISTORY

Is the patient currently sexually active? ☐YES ☐NO **Does the patient have sex with:** ☐Men ☐Women

Lifetime sexual partners: ☐Less than 5 ☐More than 5 **New sexual partners?** ☐YES ☐NO ☐Both

Has the patient ever had a sexually transmitted disease? ☐YES ☐NO

****** (the remainder of this page is for female patients only)******

Patient's age at first period_____ **How many days do periods usually last?** _____

Flow: ☐Light ☐Medium ☐Heavy **Does the patient have clots?** ☐YES ☐NO

Number of tampons per day: _____ **Cramps?** ☐YES ☐NO **Pain?** ☐YES ☐NO

Number of pads per day: _____ **Does the patient have bleeding in-between periods?**☐Yes ☐NO

How long from the start of period to start of next period? _____days.

Any problems with infertility? ☐ YES ☐NO

When was the patient's last pap smear? _____/_____/_____

Has patient had any abnormal Pap results? ☐ YES ☐NO

Where was the last Pap performed? _____

Has the patient ever had a procedure on the cervix? (Colposcopy or LEEP) ☐YES ☐NO

Has the patient had the HPV Vaccine? ☐ YES ☐NO

Has the patient gone through Menopause? ☐ YES ☐ NO if yes, at what age? _____

Has the patient had any vaginal bleeding since menopause? ☐ YES ☐ NO

Is the patient on hormone replacement therapy? ☐ YES ☐NO

If the patient was born between 1938 and 1971, did mother take DES (diethylstilbestrol) while pregnant? ☐ YES ☐ NO ☐ UNKNOWN

Obstetric History

Is the patient currently pregnant? ☐Yes ☐NO Date of last menstrual period: _____

	Number		Number
Full term births		**Stillbirths**	
Preterm Birth (less than 36 weeks)		**Abortions**	
Miscarriage		**Living Children**	
Ectopic/ Tubal pregnancy		**Total number of pregnancies**	

Past Deliveries

List all past Delivery details

Baby name	Delivery Date	Gestational Age(weeks)	Labor Length (hours)	Baby's weight	Gender	Delivery type(vaginal, c-section, VBAC)	Complications	Location of delivery
					M/F			
					M/F			
					M/F			
					M/F			
					M/F			