



Patient Registration

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

Preferred Name: _____ Preferred Language: _____

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: Hispanic or Latino Not Hispanic or Latino

Race: White Black/ African American Asian American Indian/ Alaska Native

Native Hawaiian/Pacific Islander

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

Sexual Orientation: Heterosexual(straight) Homosexual (Gay or Lesbian) Bisexual Other Unsure

Gender identity: Male Female Transgender Male Transgender Female Gender Queer Other

Preferred Pronoun (Example: He, She, Him, Her, They, Etc.): _____

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? _____



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 or 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 frequency _____
- Does the patient consume caffeine? YES NO Type and frequency: _____

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			

Have you ever been tested for HIV? Year _____

Have you ever had colon cancer screening? Approximate date _____ 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 patients assigned female at birth 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

Date of last mammogram: ____/____/_____ were the results normal? YES NO

Date of last bone density scan: ____/____/_____ were the results normal? 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