

REGISTRATION FORM

IT IS REQUIRED BY INSURANCE THAT WE OBTAIN ALL INFORMATION ON THIS FORM

NAME _____ SOCIAL SEC. # _____ DATE OF BIRTH MONTH _____ DAY _____ YR _____ SEX: M F MARRIED DIVORCED WIDOW SINGLE RACE: WHITE ASIAN AFRICAN AMER HISPANIC OTHER LANGUAGE: ENGLISH SPANISH POLISH ARABIC OTHER YOUR PRIMARY DOCTOR _____ WHO REFERRED YOU HERE _____	YOUR PAST MEDICAL HISTORY: CIRCLE ANY THAT YOU HAVE NOW OR HAVE HAD IN THE PAST <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">AIDS/HIV</td> <td style="width:33%;">HEPATITIS: A B C</td> <td style="width:33%;">CANCER: _____</td> </tr> <tr> <td>ALCOHOLISM</td> <td>HEART DISEASE</td> <td>WHERE _____</td> </tr> <tr> <td>ARTHRITIS:</td> <td>HIGH CHOLESTEROL</td> <td>HYPERTENSION</td> </tr> <tr> <td> OSTEO</td> <td>KIDNEY DISEASE</td> <td>STD</td> </tr> <tr> <td> RHEUMATOID</td> <td>PACEMAKER</td> <td>THYROID</td> </tr> <tr> <td>DIABETES</td> <td>PROSTATE PROBLEM</td> <td>OVERACTIVE-HYPER</td> </tr> <tr> <td> TYPE 1</td> <td> ENLARGED</td> <td> UNDERACTIVE HYPO</td> </tr> <tr> <td> TYPE 2</td> <td> INFECTION</td> <td>PSYCHIATRIC ISSUE</td> </tr> <tr> <td>DRUG ABUSE</td> <td>MRSA</td> <td>DESCRIBE: _____</td> </tr> <tr> <td>GOUT</td> <td>SKIN INFECTION</td> <td>_____</td> </tr> <tr> <td>PNEUMONIA</td> <td>OTHER _____</td> <td>_____</td> </tr> <tr> <td>EMPHYSEMA</td> <td></td> <td></td> </tr> </table>	AIDS/HIV	HEPATITIS: A B C	CANCER: _____	ALCOHOLISM	HEART DISEASE	WHERE _____	ARTHRITIS:	HIGH CHOLESTEROL	HYPERTENSION	OSTEO	KIDNEY DISEASE	STD	RHEUMATOID	PACEMAKER	THYROID	DIABETES	PROSTATE PROBLEM	OVERACTIVE-HYPER	TYPE 1	ENLARGED	UNDERACTIVE HYPO	TYPE 2	INFECTION	PSYCHIATRIC ISSUE	DRUG ABUSE	MRSA	DESCRIBE: _____	GOUT	SKIN INFECTION	_____	PNEUMONIA	OTHER _____	_____	EMPHYSEMA		
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<p>PHARMACY</p> YOUR PHARMACY : NAME _____ ADDRESS _____ YOUR ADDRESS: _____ _____ APT # _____	YOUR PAST SURGICAL HISTORY: TYPE OF SURGERY AND WHAT YEAR: _____ _____ _____ ALLERGIES YOU HAVE: _____ REACTION YOU HAVE: _____ DO NOT LEAVE SPACE BLANK- IF NONE-- CHECK HERE <input type="checkbox"/>																																				
<p>YOUR E MAIL ADDRESS</p> _____ _____ YOUR HOME PHONE _____ YOUR CELL PHONE _____ preferred method (check one) _____ cell _____ home EMERGENCY CONTACT NAME _____ ADDRESS _____ _____ PHONE _____ RELATION _____	ARE YOU A CURRENT SMOKER YES NO ARE YOU A FORMER SMOKER YES NO QUIT WHEN _____ MEDICATIONS YOU TAKE NOW: <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:40%;">NAME</th> <th style="width:30%;">DOSE</th> <th style="width:30%;">#TIMES A DAY</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	NAME	DOSE	#TIMES A DAY																																	
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FAMILY HISTORY:		CAUSE of		
	ALIVE ?	AGE AT DEATH	death	
FATHER				
MOTHER				
BROTHERS				birthdate
SISTERS				birthdate

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY NAME

POLICY NUMBER

NAME AND BIRTHDATE OF SUBSCRIBER IF NOT YOU:

DO ANY BLOOD RELATIVES HAVE:	RELATION TO YOU:
<input type="checkbox"/> CANCER WHERE _____	_____
<input type="checkbox"/> DIABETES	_____
<input type="checkbox"/> HEART DISEASE	_____
<input type="checkbox"/> STROKE	_____
<input type="checkbox"/> HIGH BLOOD PRESSURE	_____
<input type="checkbox"/> KIDNEY DISEASE	_____
<input type="checkbox"/> ARTHRITIS	_____

DOES YOUR PLAN REQUIRE REFERRALS YES NO

SECONDARY INSURANCE

INSURANCE COMPANY NAME

POLICY NUMBER

RECENT TRAVEL-WHERE AND WHEN

OTHER INFORMATION YOU WANT TO SHARE:

I ASSIGN ALL PAYMENTS TO CROSSROADS MEDICAL GROUP. I AUTHORIZE THE USE OF MY HEALTH INFORMATION TO INSURANCE COMPANIES TO OBTAIN PAYMENT I HAVE HAD OPPORTUNITY TO VIEW OR HAVE COPY OF HIPAA POLICY . I UNDERSTAND IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE AND INFORM STAFF OF POLICY CHANGES BEFORE MY VISIT. IF INSURANCE DENIES PAYMENT DUE TO MISINFORMATION, OR A SERVICE IS DEEMED BY THEM AS BEING NON COVERED, PAYMENT FOR SERVICES IS MY RESPONSIBILITY

SIGNATURE _____

DATE _____