PLEASE PRINT

RETURN  **NEW**

Patient Registration Form

Last Name:_____ First Name: _____ MI_____

Date of Birth:_____/_____/_____ SSN:_____-_____-_____ Gender:_____

Mailing Address:_____

City_____ State_____ Zip_____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Is it ok to leave a message at the contact number listed? Y / N
Permission to leave any test results on your voicemail? Y / N [ ] Home or [ ] Cell Phone
Is this visit Worker's Comp? Y / N Is this a Motor Vehicle Accident (MVA)? Y / N

Primary Care Physician Name:_____ Phone Number:_____

Insurance Company Name:_____ Policy Holder Name:_____

Member ID: _____ Group Number: _____

Policy Holder SSN: _____-_____-_____ Policy Holder DOB:_____/_____/_____

Address _____

What pharmacy will you be using today? Name:_____ Location:_____

Emergency Contact Name:_____ Phone Number:_____

It is ok to release my Health Information to the following:

Name:_____ Relationship:_____

How did you hear about Emergency Physicians Medical Center?_____

Please return this to the Front Desk when completed with the following:

Driver's License
Insurance card(s)
Please read the laminated forms regarding HIPAA and insurance
You will be responsible for all applicable copays, coinsurance, and/or deductibles today

I hereby authorize EPMC to release pertinent medical information to insurance carriers as needed to obtain payment. I authorize EPMC to medically treat me as well as obtain x-rays, labs, IV's as needed for my treatment.

Please sign here: Name: _____ Date: _____

Continue on Back

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Reason for Visit:

_____

_____

Medications:

Name: **Dose:** **X per day:** **Reason for Rx:**

_____

_____

_____

_____

Drug Allergies: **Reaction:**

_____

_____

Medical Hx: (circle all that apply)

Diabetes I Diabetes II Hypertension Asthma

COPD Stroke Heart Attack

Other:_____

Surgical Hx: (circle all that apply)

Appendectomy Gallbladder

Hysterectomy Tonsillectomy

Other:_____

Circle one:

Never smoked Current Smoker Former Smoker **If yes, how much:**_____

Year started:_____ **Year Quit:**_____ **Do you want to quit?** Y / N

Do you drink? Yes Socially No

Family History of: Hypertension Diabetes I / II Other:_____

Have you had a Tetanus shot within the last 5 years? Y / N

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* For Staff Use Only:

BP _____ Pain _____

PULSE_____ Weight: _____

RESP_____ Height: _____

TEMP_____

0_2SAT_____