PATIENT REGISTRATION FORM

Patient Name _____
Last First MI

_____ _____ _____ _____
Address City State Zip

Home Phone _____ Cell Phone _____ SSN _____

DOB _____ Marital Status ☐ ☐ ☐ ☐ Driver's License _____ Male ☐ Female ☐
S M W D

Please provide your E-Mail address so we will be able to better serve you with reminders, updates, etc.
E-Mail address _____
I would like to receive text messages for reminders, medications, test results, etc. Yes ☐ No ☐

Primary Insurance Information

_____
Policy Holder Name DOB Relation to Policy Holder

_____ _____ _____ _____
Address City State Zip

_____ _____ _____
Insurance Name Policy # Group #

Secondary Insurance Information

_____
Policy Holder Name DOB Relation to Policy Holder

_____ _____ _____ _____
Address City State Zip

_____ _____ _____
Insurance Name Policy # Group #

Emergency Contact

_____
Name Relationship Phone
If patient is a child, who may authorize treatment? _____ Relationship _____

I assign all medical and/or surgical benefits to which I am entitled, under any and all insurance, or any other health plan to Ponderosa Family Care. I authorize the release of my medical information necessary to process claims and direct payment of benefits from my insurance company. I accept financial responsibility for all charges, including but not limited to, co-payments and annual deductibles. I have received my Medical Treatment Agreements. This includes my e-mail and phone communication preferences, as well as the Consent to Treat Agreement.

_____ _____
Signature of patient, parent or legal guardian Date

PATIENT REGISTRATION FORM

CHIEF MEDICAL COMPLAINT/REASON FOR VISIT

☐ Antibody Blood Test ☑ Nasal Swab

PAST MEDICAL HISTORY:

☐ **Heart disease** ☐ **Lung disease** ☐ **Asthma**
☐ **Hypertension** ☐ **Thyroid disease** ☐ **Intestinal disease**
☐ **Neurologic disease** ☐ **Stroke** ☐ **Diabetes**

PAST SURGICAL HISTORY:

☐ **Open heart surgery** ☐ **Stents** ☐ **Intestinal surgery**
☐ **Brain surgery**

FAMILY HISTORY:

☐ **Diabetes** ☐ **Heart disease** ☐ **Kidney disease**
☐ **Lung disease** ☐ **Cancer**

MEDICATIONS AND ALLERGIES

DRUG ALLERGIES

☐ **Penicillin** ☐ **Keflex** ☐ **Contrast Dye**
☐ **Iodine** ☐ **Other**

FOOD ALLERGIES

☐ **Peanuts** ☐ **Citrus**
☐ **Other**

MEDICATIONS

☐ **Metoprolol** ☐ **Atenolol** ☐ **Lorartan**
☐ **Lisinopril** ☐ **Levothyroxin** ☐ **Albuterol**
☐ **Inhalers** ☐ **Atorvastatin** ☐ **Crestor**
☐ **Lasix** ☐ **Hydrochlorothiazide**

1 Drug: Dosage: Frequency: For:
2 Drug: Dosage: Frequency: For:
3 Drug: Dosage: Frequency: For:

Preferred Pharmacy _____

SOCIAL HISTORY

☐ **Do you drink alcohol?** ☐ **Do you drink caffeine?**
Do you use tobacco? ○ **Current** ○ **Former** ○ **Never** ○ **Unknown**
Do you use chewing tobacco? ○ **Current** ○ **Former** ○ **Never** ○ **Unknown**

Recent Travel:
☐ **Out of state** ☐ **Out of Country**

REVIEW OF SYSTEMS

Constitutional

☐ **Fatigue** ☐ **Fever** ☐ **Night Sweats**

PATIENT REGISTRATION FORM

REVIEW OF SYSTEMS (cont.)

Respiratory:

☐ **Cough** ☐ **Shortness of breath** ☐ **Wheezing**

Cardiovascular:

☐ **Chest Pain** ☐ **Irregular heartbeat/palpitations**

Gastrointestinal:

☐ **Nausea** ☐ **Vomiting** ☐ **Diarrhea**
☐ **Abdominal Pain**

Skin:

☐ **Rash**

Musculoskeletal:

☐ **Muscle Pain** ☐ **Joint Pain**

Neurologic:

☐ **Loss of sense smell** ☐ **Balance disorder** ☐ **Speech problems**
☐ **Thinking problems**

Psychiatric:

☐ **Anxiety** ☐ **Depressed Mood**

TO ENSURE THAT YOU DO NOT HAVE AN EXTENDED WAIT, PLEASE INDICATE THE DAY AND TIME YOU WOULD PREFER FOR YOUR TEST.

PLEASE INDICATE YOUR PREFERENCE FOR CONFIRMATION BACK TO YOU.

EMAIL ○ **OR TEXT TO YOUR CELL** ◉

TUESDAY ○ **WEDNESDAY** ○ **THURSDAY** ◉ **FRIDAY** ○

9:00 ◉ **9:30** ○ **10:00** ○ **10:30** ○ **11:00** ○ **11:30** ○ **12:00** ○ **12:30** ○

Reset Form Submit Form