Parkview Internal Medicine

PATIENT REGISTRATION

Last Name:_____________________________ **First Name:**__________________________ **Middle Initial:**_______

DOB:_____ /______ /______ **Sex:** ☐ ***Male*** ☐ ***Female*** ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ____________________

Home Address:____ **Apt #:**____________________

City:_____________________________________ **State:**_____________________ **Zip:**______________________

Home #: (_____)_______________ **Work #:** (______)_____________ **EXT:**______ **Cell #:** (______)___________

Preferred Daytime Phone: ☐ Home ☐ Cell ☐ Work

Email:____ **Employer:**____________________________________

IF WINTER VISITOR, PLEASE LIST YOUR PERMANENT ADDRESS

Address (PO BOX): **City:** **State:** **Zip:**

ADDITIONAL INFORMATION

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Other:______________________

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other: _______________________________________

Preferred Language: ☐ English ☐ Spanish ☐ Other:____

☐ do not want to provide this information

EMERGENCY CONTACT INFORMATION

Name:____ **Relationship:**______________________________

Home #: (_____)_________________________ **Work #:** (_____)_______________________________

PREFERRED PHARMACY

Name:____ **Phone #:** (______)________________________

Location (Crossroads):____

Mail-Order Pharmacy:____

PREVIOUS PHYSICIAN INFORMATION

Physician Name: ____

Phone Number: (______) ______________________________

Fax Number: (______) ________________________________

Office Address:____

Financial /Insurance Information

PRIMARY INSURANCE

Insurance Name:____

Policy Holder's Name:__________________________ **Employer:**______________________________

Policy Holder's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: __________________

Policy Holder's DOB:_________________ **SS#:**____________________ **Sex:** ☐ ***Male*** ☐ ***Female***

Member ID #:________________________________ **Group #:**_______________________________

SECONDARY INSURANCE

Insurance Name:____

Policy Holder's Name:__________________________ **Employer:**______________________________

Policy Holder's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: __________________

Policy Holder's DOB:_________________ **SS#:**____________________ **Sex:** ☐ ***Male*** ☐ ***Female***

Member ID #:________________________________ **Group #:**_______________________________

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT

Responsible Party Name:______________________ **DOB:**___________________ **SS#:**_________________

Address:_______________________________________ **Relationship to Patient:**____________________

City:____________________ **State:**______ **Zip:**________ **Employer:**______________________________

Home #: (_____)_______________ **Work #:** (_____)_______________ **Cell #:** (_____)____________________

BENEFIT ASSIGNMENT / ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby authorize PARKVIEW INTERNAL MEDICINE to treat the above named patient. I authorize release of medical information necessary to process insurance claims concerning the patient's illness and treatment. Photocopies are valid as original. I authorize payment of medical benefits for medical care rendered to my dependents or myself. I understand that I am financially responsible for any amounts not covered by health insurance. It is my responsibility to notify the office of changes in information.

Signature:____ **Date:**______________________

Patient’s Medical History

MEDICATIONS

Medication Name:	Strength:	Dose:	Frequency:

ALLERGIES

☐ Patient has no known allergy ☐ Patient has no known drug allergy ☐ Latex ☐ Keflex
☐ Penicillin ☐ Sulfa ☐ Eggs ☐ Ciprofloxin ☐ Iodine
☐ Other: ____

PAST / PRESENT MEDICAL CONDITIONS

Cardiac: ☐ Heart Attack ☐ Atrial Fibrillation ☐ Congestive Heart Failure ☐ Hypertension ☐ Irregular Heart Beat
Neurology: ☐ Stroke ☐ Seizures/Epilepsy ☐ Dementia ☐ Parkinson's
Endocrine: ☐ Diabetes ☐ Thyroid Disorder ☐ Osteoporosis ☐ Elevated Cholesterol
Lungs: ☐ Asthma ☐ COPD ☐ Valley Fever ☐ Sleep Apnea ☐ Lung Cancer
Gastrointestinal: ☐ GERD ☐ Colon Cancer ☐ IBS ☐ Cirrhosis/Liver Disease
Urinary: ☐ Enlarged Prostate ☐ Kidney Stones ☐ Prostate Cancer ☐ Kidney Failure
Rheumatology: ☐ Arthritis ☐ Fibromyalgia ☐ Lupus
Blood: ☐ Anemia ☐ Leukemia ☐ Lymphoma ☐ Bleeding Disorder
Psychiatric: ☐ Anxiety Disorder ☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia
Circulation: ☐ DVT ☐ Pulmonary Embolus ☐ Peripheral Vascular Disease ☐ Carotid Artery Disease
Cancer: ☐ Cancer (type)
Other Condition(s) not listed:____________________________________ ☐ NONE

HOSPITAL & SURGERY HISTORY

DATE:	SURGERY/REASON FOR HOSPITAL STAY:

FAMILY HISTORY

FAMILY MEMBER	AGE	ALIVE/DECEASED	MEDICAL CONDITION(S)
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

SOCIAL HISTORY

Caffeine: ☐ Yes ☐ No If yes, how much? ____________________

Alcohol: ☐ Yes ☐ No If yes, how much/often? ____________________

Smoking: ☐ Yes ☐ No ☐ Former If yes, how many/often? ____________________

Marijuana: ☐ Yes ☐ No If yes, how often? ____________________

Exercise: ☐ Yes ☐ No If yes, what and how often? ____________________

Living Will: ☐ Yes ☐ No

Retired: ☐ Yes ☐ No

PREVENTIVE CARE

Date of last physical exam: ____________________

Date of last mammogram: ____________________

Date of last colonoscopy: ____________________

Date of last bone density scan (DEXA): ____________________

Date of last Pap smear: ____________________

Date of last PSA: ____________________

Date of last stool test: ____________________

IMMUNIZATIONS

Hep. A: ☐ Yes ☐ No Date received: ____________________

Hep. B: ☐ Yes ☐ No Date received: ____________________

Influenza: ☐ Yes ☐ No Date received: ____________________

Pneumonia: ☐ Yes ☐ No Date received: ____________________

Prevnar 13: ☐ Yes ☐ No Date received: ____________________

Tetanus: ☐ Yes ☐ No Date received: ____________________

Shingles: ☐ Yes ☐ No Date received: ____________________

TB: ☐ Yes ☐ No Date received: ____________________

MMR: ☐ Yes ☐ No Date received: ____________________