The Family Physicians PA.
REGISTRATION FORM

Today's Date: [Date]	PCP: [PCP]

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Why did you choose our clinic?

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No

Please indicate primary insurance: Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber: Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Family Physicians PA. or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

ADULT HEALTH HISTORY

Date _____

Name _____

Date of birth _____ Age _____

General health _____

Are you currently or have you ever been treated for

Yes	No	Condition	Explain
		Asthma	
		Bleeding disorders	
		Blood Pressure	
		COPD	
		Diabetes	
		Ear/sinus	
		Fainting	
		Gastro-intestinal problems	
		Heart disease	
		Kidney disease	
		Learning disorders	
		Menstrual problems	
		Musculo-skeletal	
		Psychological/psychiatric	
		Seizures	
		Sickle cell disease	
		Sleep disorders	
		Stroke	
		Surgery	
		Thyroid disease	
		Serious injury	
		Other	

List all medications you are currently taking, including over-the-counter drugs and herbal supplements

Medication	Dosage	Reason

Allergies

Signature _____