Registration Form

Please Print

Date _____ Home Tel. #._____

Name (last) _____ (first)_____

Responsible party (if a minor)_____

Street address_____

City_____ State_____ Zip_____

SS# _____ DOB _____ Single Married Divorced Widowed Separated

Patient employed by _____

Occupation _____Work telephone _____

Spouse _____ SS#_____ DOB_____

Spouse employed by _____ Work telephone _____

Do you have medical insurance Y N

Name of insurance _____ Policy holder _____

Address _____

ID#_____ Group #_____

Name of secondary insurance _____ Policy holder_____

Medicare? Medicaid? ID#_____

In case of emergency, who should be notified? _____ #_____

How did you learn about our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with (name) _____ and assign directly to Dr. Stephanie Fulton all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the doctor to release all information necessary to secure benefit payments. I authorize the use of this signature on all my insurance submissions.

Signature_____ Date _____

Allergies?

_____

REASON FOR VISIT:_____

PAST MEDICAL HISTORY: Please check (x) if you or any blood relative had any of the following conditions

	Self	Family
Wt. Loss/gain	_____	
Headaches/migraines	_____	
Heart disease	_____	_____
Hypertension	_____	_____
High Cholesterol	_____	_____
Lung disease	_____	_____
Breast disease	_____	_____
Jaundice/hepatitis	_____	_____
Reflux/Hiatal hernia	_____	
Peptic ulcer	_____	
Bowel disease	_____	_____
Kidney disease	_____	_____
Urinary Incontinence	_____	_____
Urinary infections	_____	
Pelvic pain	_____	_____
Blood transfusions	_____	
Anemia/Blood disor.	_____	_____
Varicose Veins/phlebitis	_____	_____
Diabetes	_____	_____
Thyroid disease	_____	_____
Cancer (type)	_____	_____

Epilepsy	_____	_____
Alzheimer	_____	_____
Arthritis (joint pain)	_____	_____
Osteoporosis	_____	_____
Skin disease	_____	
Unwanted facial hair	_____	
Anxiety/depression	_____	_____
Sleep disord.	_____	

HOSPITAL ADMISSIONS: List those operations and serious illnesses that required hospitalization, (exclude pregnancy)

Year Reason for hospitalization

MEDICATION: List all medicines you are currently taking, does, how often, including over the counter

MENSTRUAL HISTORY:

Age at 1st period if still menstruating, last cycle –

Interval, number of days form 1st day to 1st day- Duration of bleeding-

Cramps: Y N Mild- Severe- Medication for cramps?

How many periods in the last year- Bleeding between periods-

INFECTIONS:

Vaginal - type

Pelvic infections- gonorrhea, Chlamydia, Herpes, other STDs?

PAP TEST: last test _____ Normal Abnormal

MAMMOGRAM: last test _____ Normal Abnormal

CONTRACEPTIVE HISTORY: Current method_____ Past _____

OBSTETRICAL HX: # pregnancies _____ Premature_____ Miscarriages_____Abortions____

Living children_____

Born yr/mos	Wks. Prg.	Sex	Type of delivery	Problems?

MENOPAUSAL TREATMENT: If applicable, hot flashes? Treatment?

SEXUAL HISTORY: satisfactory? uncomfortable? wish to discuss?

SOCIAL HISTORY: Smoking # yrs? Coffee? Amt/day Alcohol? Amt/day Street drugs?