New Patient Registration – Insurance Holder Beneficiary

Patient Information

Patient's Full Name				SSN:
Permanent Address				
City	State		Zip Code	
Phone Number where we can contact you or leave you a message:	Sex (circle one) M F	Date of Birth	Drivers License:	
Referring Physician's Name/Address	Referring Dr.'s Phone No. ( )			

In Case of Emergency Notify	Relationship with you?	Phone No. ( )	
Was the Injury Job Related? Yes No	Date of Injury	Was the Injury the result of an Accident? Yes No	Date of Accident
Claim Number		Has the Case been settled? Yes No	Date
Do you have an Attorney? Yes No	If yes, Name/Address of Attorney	Phone No. ( )	

Insurance Holder

Insurance Holder's Full Name		Relationship with you?	
Sex M F	Date of Birth	Age	Marital Status (circle one) Single Married Widowed Divorced
Permanent Address			
Home Phone ( )	Social Security No.	Drivers License No./State issued	
Employer's Name and Address			
Work Phone No.	Occupation and How Long Employed?		

Insurance Information

Primary Insurance Carrier		Secondary Insurance Carrier	
Address		Address	
Subscriber Name		Subscriber Name	
Group Name		Group Name	
Policy I.D.	Group No.	Policy I.D.	Group No.
Referral Number:	Authorization Number:	Referral Number:	Authorization Number:

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe, may cause to incur full liability for professional charges, as a result of non-payment by any carrier.

____ ____________________

Responsible Party's Signature Date

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Dear Patient: We want to provide you with excellent medical care. To do so we need to know about your health history and other habits. Please help us by filling this questionnaire completely. We will be more than glad to help you fill this form if needed, just notify the receptionist.
Estimado paciente: Queremos proveerle servicios medicos de excellencia. Ayudenos llenando este cuestionario en su totalidad. Si necesita ayuda para llenar las formas, notifique a la recepcionista y con mucho gusto le ayudaremos.

ILLNESS/ *Enfermedades*	Yes/Si	NO	DON'T KNOW/ No sé
Any infectious or Contagious Illness */ Enfermedades Contagiosas o Infecciosas*			
Diabetes			
Birth Abnormalities / *Defectos Congénitos*			
Cancer			
Heart Disease / *Enfermedad del corazón*			
Pacemaker / Marcapaso			
High Blood Pressure / *Presion Alta*			
Thyroid Disease / *Enfermedad tiroidea*			
Any Rheumatic Illness / *Enfermedad reumática*			
Asthma or Pulmonary Disease / Asma o Enfermedad del pulmon			
Any other serious illness? / *Alguna Otra Enfermedad*			

Surgery / Cirugia	Date / Fecha
1	
2	
3	
4	

Hospitalizations (Date and reason) Other than surgery / Hospitalizacion (Fecha y Razon) aparte de cirugia
1
2
3
4

Inheritable Diseases / Enfermedades Hereditarias

Disease / Enfermedad	Family Member / Familiar
1.	
2.	

FAMILY LIFE, WORK, AND RECREATIONAL HABITS [SOCIAL HISTORY]: *Historia de habitos sociales*
Marital Status: (Estado Civil): ___________________
Who lives with you at home?circle *Quien vive contigo?circule Spouse/Coyugue Children/Hijos Other/Otros*
Personal History: Cigarettes (# / day / # yrs) ___________ Alcohol (oz. / day)_______ Coffee (cups / day) ___
Do you abuse or have abused legal or illegal drugs**? Ha Abusado de las drogas, legales o ilegales** ☐No, ☐Yes,
Are you presently employed? Trabaja ☐Yes/Si ☐No, if no explain _____________________________________
Occupation or Trade (Ocupación o Destreza)? _______________
Do you feel stressed at home, school or work? __________________________________

Place Patient Label Here

SYMPTOMS THAT MAY BOTHER YOU [SYSTEMIC REVIEW]: Sintomas que le molestan

GENERAL SYMPTOMS	NO	YES	IF YES, PLEASE DESCRIBE
Weight changes? Cambio en el peso ?			
Chest or Heart problems ? Problema de pecho o corazón ?			
Eye problems or injuries / glasses / contacts ? problemas de vision / herida / lentes / contactos ?			
Stomach or intestinal problems or Ulcers ? Problemas estomacales o intestinales o ulceras?			
Liver problems ? / Problema del hígado ?			
Asthma or wheezing ? / Asma, soplillo o pitillo?			
Bladder, voiding or kidney problems ? Problema de vejiga, urinario o del riñon ?			

Nervous and Muscular Symptoms	NO	YES	If yes, please describe
Headaches / Dolores de cabeza			
Muscle weakness / debilidad muscular			
Difficulty walking / dificultad para caminar			
Pain upon walking / dolor al caminar			
Leg / feet pain / dolor de pie o pierna			
Arms / hands pain / dolor de mano o brazo			
Numbness / adormecimiento de la piel			
Abnormal skin sensations / sensaciones anormales de la piel			
Back pain /dolor de espalda			
Attention, concentration or memory problems / problemas de atención, concentración o memoria			
Difficulty with speech or language use / dificultad de lenguaje			
Difficulty swallowing liquids or solids Dificultad para tragar sólidos o liquido			
Depression / Depresion			
Anxiety or Panic Attacks /Ansiedad o ataque de pánico			
Fainting spells / Desmayos			
Dizziness or vertigo / Mareos			
Paralysis / Paralisis			
Seizures or convulsions / Convulsiones			

☐ **Check here if male and skip section. /Si es varón deje esta área en blanco y siga a la próxima pregunta**

Gynecological (ladies only)	Yes	NO	If "no" please describe
Regular Periods / periodos regulares			
Pap smear normal? / papanicolao normal?			
Last Menstrual period / ultimo periodo menstrual			

Place Patient Label Here

Allergies / Alergias

DRUG OR FOOD (Droga o Alimento)	DESCRIBE ALLERGY OR REACTION (describa su reacción)
1.	
2.	
3.	
4.	
5.	
6.	

PLEASE LIST ANY DRUGS TAKEN AT PRESENT; INCLUDE PRESCRIPTION AND NON PRESCRIPTION: Por favor liste cualquier droga que este tomando ahora ; incluyendo receta y sin receta:
PLEASE DO NOT WRITE "SEE LIST", WE CAN ASSIST YOU IN FILLING THIS SECTION. THANKS

MEDICATION NAME AND STRENGTH Medicina nombre y fuerza	HOW MUCH and HOW OFTEN Cantidad y Frequencia	HOW LONG Cuanto tiempo	REASON Razon

NEUROLOGY + NEUROREHABILITATION
NEURO 1

Place Patient Label Here