



New Patient Registration – Insurance Holder

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 Age |
| 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 – additional information

| | | |
|-----------------------------|---------------------|----------------|
| Home Phone () | Driver's Lic /state | Work Phone No. |
| Employer's Name and Address | | |

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

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

