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| HCC.jpg**PATIENT INFORMATION**  TIME Paperwork completed  \_\_Staff to complete\_\_\_\_\_\_\_\_  Registration/Consent Form  (Please Print) | | | | | | | |
| Patient’s Last Name: | | First: | Middle: | | | Birth Date:  / / | |
| Street Address: | | | | Age: | | Sex:  M F | |
| PO Box: | | City: | State: | | | Zip: | |
| Email Address: | | | Home Phone #:  ( ) | | | Cell Phone#:  ( ) | |
| Social Security #: | | Employer | | | | *Employer Phone #*  *( )* | |
| Race: American Indian/Alaskan Native White    Asian Hispanic  Black or African American I do not wish to answer  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Language: | | How did you hear about us? | | |
| Primary Physician: | Pharmacy: | | **Would you like visit notes sent to physician listed?**  Yes No | | | | |
| Reason for Today’s Visit: | | | | | | | |
| Current Medications: *(If you have a list we will make a copy and attach it to this form)* | | | | | | | |
| Allergies: | | | | | | | |
| **IN CASE OF EMERGENCY WHO CAN WE CONTACT?** | | | | | | | |
| Primary Contact: | Relationship to Patient: | | Cell #: | | | Home #: | |
| Medical/Financial information may be released to Primary Contact unless indicated here. No | | | | | | | |
| **GUARANTOR/INSURANCE INFORMATION** | | | | | | | |
| Is this patient covered by Insurance?: Yes No | | | If “**NO**” payment will be collected up front | | | | |
| **Please give your insurance card and phot ID to the recepionist.**  **You must notify us if this is an accident or work related visit.** | | | | | | | |
| Person responsible for bill:  (Children under 19 only) | Birth Date: | | Address (if different): | | | | Home Phone #: |
| Insurance Company: | | | | | | | |
| Policy Holder: | | | DOB: | | | | SSN: |
| Employer: | | | Employer Phone: | | | | |
| Patient’s Relationship to Subscriber:  Child Spouse Other | | | Contact Preference:  Home Mail Work Email Cell | | | | |

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| **PATIENT NAME:** | **DOB:** |
| **Current Symptoms:** Read the following symptoms & mark all that you are experiencing today or with current illness. | |

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| **History of POSITIVE COVID19**   * YES * NO   DATE\_\_\_\_\_\_\_\_\_\_\_  **CONSTITUTIONAL**   * Change in Appetite * Chills/FEVER * Fatigue * Sweats * Weight Loss   **CARDIOVASCULAR**   * Chest Pain/Pressure * Fainting * Fluttering/Palpitations * Leg Swelling   **NEUROLOGICAL**   * Headache * Light Headedness * Loss of Consciousness * Numbness/Tingling * Poor balance * Weakness   **PSYCHIATRIC**   * Anxiety/Nerves * Depression * Sleep difficulties   **LYMPH**   * Easy Bleeding * Frequent Infections * Nodes/Glands   **NEW PATIENTSECTION ONLY** | **EYES**   * Blurred or double vision * Contact Lenses * Eye Discharge * Eye Pain * Eye Redness * Eye Swelling * Wear Eyeglasses   **ENT and Mouth**   * Difficulty Swallowing * Dizziness * Ear Pain * Hoarseness * Mouth Pain * Nasal Congestion * Nasal Discharge * Sore Throat   **MUSCULAR**   * Back Pain * Joint/Muscle Pain * Swelling   **ALLERGY/IMMUNE**   * Itchy Eyes * Lip/Tongue/Throat Swelling * Post-Nasal Drip * Sneezing | **GI**   * Abdominal Pain * Blood in Stool * Constipation * Diarrhea * Nausea * Rectal/Perirectal Complaints * Urinary/Bowel Changes * Vomiting   **GU**   * Blood in Urine * Discharge * Frequent Urination * Menstrual Complaints * Nighttime Urination * Painful Urination * Sexual Difficulties   **ENDOCRINE**   * Abnormal Blood Sugar * Cold Intolerance * Excessive Hunger/Thirst * Hair Loss * Heat Intolerance   **RESPIRATORY**   * Congestion * Cough * Shortness of Breath * Snoring * Wheeze | **SKIN**   * Bruising * Itching * Laceration * Rash * Redness * Skin sore |

**SOCIAL HISTORY**

Do you currently or have you in the past used tobacco/smokeless tobacco products? \_\_Yes \_\_No Quit \_\_Never

Do you consume alcohol? \_\_Yes \_\_No Do you use or have you in the past used illegal drugs? \_\_Yes \_\_No Quit \_\_ Never

**MEDICAL HISTORY** List all past surgeries and dates:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **IMMUNIZATIONS**  Have you received any of these vaccines?   * Flu Vaccine * TD/TDAP * **COVID Vaccine** series completed date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Are you current on your **childhood immunizations**?   * Yes * No |

**FAMILY HISTORY** Do ***you*** or a ***family member (***father, mother, or sibling) have a history of any of the following?

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| * Cardiovascular (Heart) * High Cholesterol * Cancer/Leukemia | * High Blood Pressure * Brain Aneurism * Diabetes | * Alzheimer’s * Psychiatric (Depression, Bipolar, etc.) |