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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?

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