PATIENT REGISTRATION

CARITAS
FAMILY MEDICINE

PATIENT DATA

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____ Date of Birth: _____/_____/_____

City: _____ State: _____ Zip: _____

Employer: _____ Job Title: _____

Employer Address: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Email: _____

☐ By checking this box, I consent to receive statements and invoices at the email address I have provided above.

Sex: Male / Female Driver's License #: _____ Soc Sec #: _____-_____-_____

Marital Status:_____ Race: _____ Ethnicity: _____

Primary Language: _____ Religious Preference: _____

Relationship to Responsible Party: _____

Preferred Pharmacy _____ Pharmacy Phone #: (_____)_____-_____

RESPONSIBLE PARTY FOR BILLING PURPOSES (if different from patient)

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____ Date of Birth: _____/_____/_____

City: _____ State: _____ Zip: _____

Employer: _____ Job Title: _____

Employer Address: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Sex: Male / Female Email: _____

Driver's License #: _____ Soc Sec #: _____-_____-_____ Marital Status:_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Telephone: (_____)_____-_____

INSURANCE INFORMATION

Primary Company: _____ Policy Number: _____ Group Number: _____

Effective Date: _____/_____/_____ Subscriber: _____ Subscriber Date of Birth: _____/_____/_____

Secondary Company: _____ Policy Number: _____ Group Number: _____

Effective Date: _____/_____/_____ Subscriber: _____ Subscriber Date of Birth: _____/_____/_____

Tertiary Company: _____ Policy Number: _____ Group Number: _____

Effective Date: _____/_____/_____ Subscriber: _____ Subscriber Date of Birth: _____/_____/_____

I hereby authorize Dr. Cannon and Dr. Rosedale to furnish information to my insurance carriers and other consulting physicians, hospitals, radiologists, pharmacies, and laboratories for purposes of treatment, diagnosis, payment or health care operations. I assign to Dr. Cannon or Dr. Rosedale all payments for medical services rendered to me or to my dependents. I understand that I am responsible for any amount not covered by my insurances. I understand that payment of any deductibles or co-pays is expected at the time of service unless other arrangements have been made in advance.

Signature: _____ Date: _____

Bring this paperwork to your appointment, or you can email to caritasefaxdocument@gmail.com.

CARITAS
FAMILY MEDICINE

RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

WRITTEN ACKNOWLEDGEMENT FORM

Patient Name: _____ DOB: _____

I have received a copy of Caritas Family Medicine PA's Notice of Privacy Practices.

By signing below, I acknowledge that I have received the *Notice of Privacy Practices* prior to any service being provided to me by the Practice, and I consent to the use and disclosure of my medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Signature (Patient/Legal Representative): _____ Date:_____

If Legal Representative, relationship to Patient: _____

❑ Patient/Guardian offered *Notice of Privacy Practices*, but declines to accept/acknowledge.

_____ _____

Witness Date

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CARITAS
FAMILY MEDICINE

FEMALE MEDICAL HISTORY

Name: _____ **Date: ____/_____/_____ DOB: ____/____/_____**

Do you now have, or have you ever had:

Disease	✓	Date First Diagnosed
High blood pressure		
Heart problems		
High cholesterol		
Stroke		
Other circulation problems		
Diabetes		
Thyroid problems		
Asthma / Emphysema / Chronic bronchitis		
Neck problems		
Back problems		
Arthritis		
Migraines		
Seizures		
Cancer		
Allergies		
Depression		
Anxiety		
Other mental illness		
HIV/AIDS		
Other major health problems		

Have you ever had any of the following surgical procedures?

Procedure	✓	Date Performed if Known
Tonsillectomy		
Ear tubes		
Sinus surgery		
Neck repair		
Back repair		
Shoulder repair		
Hip repair		
Knee repair		
Ankle or foot repair		
Cataract removal		
Other eye surgery		
Heart bypass or valve repair		
Appendectomy		
Gallbladder removal		
Hysterectomy		
Ovary removal or repair		
Breast reduction / augmentation		
Tubal ligation		
Caesarean section		
Kidney stone removal		
Hernia repair		
Blood transfusion		
Other major procedure		

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CARITAS
FAMILY MEDICINE

GYNECOLOGICAL HISTORY

Age at onset of menses: _____

Number of times pregnant: _____

Full term deliveries: _____

Premature deliveries: _____

Miscarriages: _____

Abortions: _____

Number of living children: _____

Date of last menses: _____

HEALTH MAINTENANCE

Date of last pap smear: _____

Date of last mammogram: _____

Colon cancer screening: _____

FAMILY HISTORY:

Disease	Mother	Maternal Grandmother	Maternal Grandfather	Father	Paternal Grandfather	Paternal Grandmother	Siblings
High blood pressure							
Heart disease							
Stroke							
Diabetes							
Thyroid disease							
Asthma							
Tuberculosis							
Seizures							
Breast cancer							
Lung cancer							
Colon cancer							
Prostate cancer							
Ovarian cancer							
Other cancer							
Migraine							
Mental illness							
Alcoholism							
Bleeding disorders							
Other major diseases							

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SOCIAL HISTORY

Current Marital Status: ❑ Married ❑ Widowed ❑ Single ❑ Divorced ❑ Separated

Current Education Level: ❑ Elementary ❑ High School ❑ College ❑ Post-graduate

Ethnic Background: _____ Religious Preference: _____

Current Occupation: _____

Have you had any jobs involving exposure to asbestos, coal dust, toxic chemicals or radiation? Y N

HEALTH HABITS

Do you exercise on a regular basis? Y N Type of exercise: _____

How many days per week? _____ How many minutes each time? _____

How many meals per day do you eat? _____ Do you eat breakfast most days? Y N

Do you add salt at the table? Y N About how many calories do you eat each day? _____

How many servings of the following types of food do you eat each day?

Protein: _____ Dairy: _____

Fruit: _____ Vegetables: _____

Grains: _____ Water: _____

Have you had more than one sexual partner in the past two years? Y N

What is your sexual orientation? ❑ heterosexual ❑ lesbian ❑ bisexual

Do you drink alcohol? Y N If yes, how many drinks per week on average? _____

Have you ever used any street or 'recreational' drugs? Y N

If yes, which ones? _____ If yes, any injectables? _____

Have you ever used any tobacco products? Y N

If yes, are you a current smoker? Y N How many packs per day? _____ Started at what age? _____

Do you have a completed Directive to Physician ('living will')? Y N

If yes, with whom is it filed? _____

Do you have a completed Medical Power of Attorney? Y N

If yes, with whom is it filed? _____

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MEDICATIONS

Please list any medications to which you are allergic:

MEDICATION	TYPE OF REACTION

Please list ALL medications which you take (including over-the-counter products):

MEDICATION	STRENGTH	HOW OFTEN?	REASON

IMMUNIZATIONS

VACCINE	DATE OF MOST RECENT
Tetanus	
Pneumonia	
Influenza	
Other:	

Please list any other physicians / specialists who are providing you with care:

NAME	REASON

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