Patient Registration Information

Please PRINT AND complete ALL sections below!

Patient's Personal Information **Marital Status:** □ Single □ Married □ Divorced □ Widowed **Sex:** □ Male □ Female

Name: ______________________ ______________________ ________
last name first name initial

Date of Birth: ____________ Social Security #: ________________ Race/Ethnicity __________ Language ____________

Home Phone: ____________ Work Phone: ______________ Cell Phone: ______________ E-Mail: __________________

MAILING Address: __________________________ Apt #: ____ City: ________________ State: _____ Zip: __________

Patient's/Responsible Party Information **Relationship to Patient:** □ Self □ Spouse □ Child □ Other: __________

Name: ______________________ ______________________ ________
last name first name initial

Date of Birth: ____________________ Social Security #: ______________________

Home Phone: ____________________ Work Phone: ______________________ Cell Phone: ______________

Address: __________________________ Apt #: _____ City: ________________ State: _____ Zip: __________

Emergency Contact

Name: ____ Relationship: ______________________

Address: __________________________ Apt #: _____ City: ________________ State: _____ Zip: __________

Home Phone: ____________________ Work Phone: ______________________ Cell Phone: ______________

Family History Fill in health information about your immediate family

Relation	Age	State of Health	Age at Death	Cause of Death		Check if your blood relatives had any of the following: Disease	Relationship to you
Father						Arthritis/Gout	
Mother						Asthma/Hay Fever	
Brother(s)						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease/Strokes	
Sister(s)						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitilizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? □ Yes □ No

If yes, please give approximate dates ______________________

Serious Illness/Injury	Date	Outcome

Pregnancies

Year of Birth	Gender	Complications if any

Health Habits Check which you use and how much

	Caffeine	
	Tobacco	
	Alcohol	
	Street Drugs/Other	

Occupational Check if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation:

Medications List medications you are currently taking

Allergies

Pharmacy Name/Location: ____________________ Your Preferred Means of Communication: ________________________

I have reviewed the HIPPA – Notice of Privacy Practices notice. __________(initial)

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Miramont Family Medicine, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: ____ Date: ______________________