Patient Registration & Health Questionnaire

Michiana Internal Medicine, PC

PATIENT

Last Name First Name Initial

Street Address

City State Zip Code

Social Security Number ______ – ______ – ______

If under 18, parent/guardian

Last Name First Name Initial

Marital Status (circle one) **S M W D Sep**

Birth Date (Month/Day/Year) ____________________

Occupation Employer

Phone Numbers

Home (   ) – Cell (   ) –

Work (   ) –

SPOUSE

Last Name First Name Initial

Occupation Employer

Phone Numbers

Home (   ) – Cell (   ) –

Work (   ) –

REASON FOR VISIT

____

____

MEDICATIONS & HOSPITALIZATIONS

List all prescription and over the counter medications you are currently taking:

Prescription/Medication Name	Strength	Frequency	Rx	OTC
			☐	☐
			☐	☐
			☐	☐

Prescription/Medication Name	Strength	Frequency	Rx	OTC
			☐	☐
			☐	☐
			☐	☐

List medications that you are allergic to: ☐ I do not have any drug allergies

____

FAMILY HISTORY

	Alive & Well	Deceased	Age and Cause of Death
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

SOCIAL HISTORY

Check all that apply:

Caffeine Use ☐ Often ☐ Occasionally ☐ Never

Drink Alcohol ☐ Often ☐ Occasionally ☐ Never

Tobacco Use ☐ No, never smoked

☐ Used to smoke, quit smoking in ____________

☐ Currently smoke, have smoked for ______ years

☐ cigarettes ☐ cigars ☐ pipe ☐ smokeless

Daily amount of ____________________

FOR WOMEN ONLY

Regular Menstrual Period ☐ Yes ☐ No

Menopausal Symptoms ☐ Yes ☐ No

Birth Control Method B.C. Pill (Brand)

____ No. of Pregnancies ____ No. of Live Births ____ No. of Miscarriages

Patient Registration & Health Questionnaire, cont'd

Michiana Internal Medicine, PC

MEDICAL HISTORY

Check box if you have had trouble with any of the following

Cardiovascular	Past	Present
High Blood Pressure		
Coronary Heart Disease		
Heart Murmur		
Palpitations		
Irregular Pulse		
Varicose Veins		
Genitourinary		
Kidney Stones		
Frequent Urination		
Prostate Problems		
Psychiatric		
Depression		
Mental Illness		
Hematologic		
Hepatitis		
Blood Clots		
Jaundice		
Bruising		
Anemia		
Excessive Sweating		

Ear, Nose, Throat	Past	Present
Hearing Problems		
Nose Bleeds		
Difficulty Swallowing		
Sinus Trouble		
Hoarseness		
Gastrointestinal		
Heartburn		
Peptic Ulcer Disease		
Colitis		
Musculoskeletal		
Gout		
Arthritis		
Dermatological		
Eczema		
Psoriasis		
Rash		
Endocrine		
Thyroid		
Diabetes		

Eyes	Past	Present
Glaucoma		
Cataracts		
Neurology		
Stroke		
Seizures		
Migraines		
Asthma/Allergies		
Asthma		
Hay Fever		
Allergies		
Hives		
Infectious Disease		
Venereal Disease		
Herpes		
Chlamydia		
Gonorrhea		
Tuberculosis		

Cancer

Other, please list

____

____

INSURANCE & BILLING INFORMATION

Billing name (if other than patient) ____ Relationship ____ Phone ( ) –

Billing Address ____

Payment required at time of service—unless prior arrangements have been made.

1 Insurance Company ____ Address ____ Effective Date ____

Name of Insured ____ Relationship ____ Group # ____ ID # ____ Benefit Code ____

2 Insurance Company ____ Address ____ Effective Date ____

Name of Insured ____ Relationship ____ Group # ____ ID # ____ Benefit Code ____

Medicare ID # ____ Medicaid ID # ____ Other Coverage ____

Pharmacy Name ____ Address ____ Phone ( ) –

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. ____________________ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

HIPAA PRIVACY PRACTICE

I acknowledge that I have received and/or have been given the opportunity to review this office's notice of HIPAA Privacy Practices for protected health information.

A photocopy of these assignments shall be valid as the original.

____

Patient/Guardian Signature

Date (Month/Day/Year)______________________