

<i>Office Use Only</i>	
<i>Hx</i>	_____
<i>Demos</i>	_____
<i>ROS</i>	_____
<i>Portal</i>	_____
<i>Pmt</i>	_____

Patient Registration Form

Date of Appointment: _____

Patient Information

Last Name (as it appears on insurance card or ID)		First Name	Middle Name	Preferred Name (ex. "Mike" or "Jenn")	
Sex	Social Security Number		Marital Status		Date of Birth
Patient's Billing Address			Apt/Unit Number	City	State Zip
Home Phone		Mobile Phone		Email Address	
Preferred Pharmacy Name	Pharmacy Phone		Pharmacy Address		

Race			Ethnic group		
<input type="checkbox"/> African American / Black Native	<input type="checkbox"/> American Indian / Alaska	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic / Latino	<input type="checkbox"/> Non-Hispanic / Latino	<input type="checkbox"/> Decline
<input type="checkbox"/> Caucasian / White	<input type="checkbox"/> Native Hawaiian / Pacific Islander	<input type="checkbox"/> Other Race	<input type="checkbox"/> Decline		

Patient Employer/School Information

Employer/School	Occupation	Employment Status
		<input type="checkbox"/> Full-time employed <input type="checkbox"/> Part-time employed <input type="checkbox"/> Not employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student <input type="checkbox"/> On active military duty <input type="checkbox"/> Decline/other

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

If anyone else should be involved in your Medical care, please indicate here:

Name		Name	
Phone Number	Relation to Patient	Phone Number	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan Number	Group Number
Insurance Claim Address (As listed on the back of the card)		Insurance Phone Number

Secondary Health Insurance

Insurance Company	Plan Number	Group Number
Insurance Claim Address (As listed on the back of the card)		Insurance Phone Number

Policyholder Information

Name of Policy Holder	Date of Birth	Relation to Patient	
Social Security Number	Phone Number		
Address	City	State	Zip

Is the reason for your visit related to an Injury or accident?

No Yes



Please notify the Front Desk Staff if you have been in an auto accident or have a Work-Related injury

If Yes, place of injury/accident::

Please explain injury/accident:

What brings you to the office today?

Do you have any chronic medical conditions?

Current Medications

What medications are you currently taking? None

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Are you allergic to any of the following? None

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Local Anesthetics |

Do you have any other allergies?

Name	Reaction
_____	_____
_____	_____

Past Medical History

- | | | | | | |
|---|--|--|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Hepatitis - A, B, or C | <input type="checkbox"/> Measles | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Joint Disorder | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> None of the above |

Hospitalizations & Surgeries

Reason	Date
_____	_____
_____	_____

Women Only:

# of Pregnancies	# of Miscarriages	# of Abortions	# of Living
_____	_____	_____	_____
Last Pap Smear	Last Mammogram	Birth Control Method	
_____	_____	_____	

Family History

Has anyone in your family ever had any of the following conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder |

Details:

Lifestyle Factors

Are you sexually active?

Yes No # of partners in past year _____

Have you ever smoked?

Yes No # of years _____ # packs/day _____

Do you smoke now?

Yes No # packs/day _____

Do you drink alcohol?

Yes No # times/week _____

Do you use recreational drugs?

Yes No Types? _____ # times/week _____

How often do you exercise?

times/week _____

Review of Systems

CAGE: Do you drink Alcohol?

- No
- Yes (please answer if any apply):
 - I have felt I need to cut down on my drinking
 - People have annoyed or criticized me about my drinking
 - I have felt guilty about my drinking
 - I have felt like I needed a drink first thing in the morning

PHQ2: In the past 2 weeks:

- I have had little interest or pleasure in doing things
- I have felt down, depressed, or hopeless

General

- Chills
- Dizziness
- Fainting
- Fever
- Hair Loss
- Hair Growth – Excessive
- Night Sweats
- Sleeping Problems
- Thirst - Excessive
- Weight Gain
- Weight Loss

Mental Health

- Anxiety
- Depression
- Loss of Interest
- Feeling Hopeless
- Hearing Voices
- Marital Problems
- Panic Attacks
- Trouble Concentrating
- Suicide –Thoughts/Attempts

Skin

- Acne
- Bruise Easily
- Change in Moles
- Chills
- Dry / Sensitive Skin
- Eczema
- Hives
- Itching
- Rash
- Scars
- Sores That Won't Heal

Gastrointestinal

- Appetite Gain
- Appetite Loss
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Indigestion
- Intestinal Disorder
- Lactose Intolerance
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

Genitourinary

- Blood in Urine
- Lack of Bladder Control
- Frequent Urination
- Painful Urination

Neurological

- Coordination Problems
- Convulsions
- Difficulty Walking
- Learning Disabilities
- Light-headedness
- Memory Loss
- Numbness / Tingling
- Paralysis
- Seizures
- Speech Problems
- Tremors

ENT

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty swallowing
- Double Vision
- Earaches
- Ear Discharge
- Hay Fever
- Hoarseness
- Hearing Loss
- Nose-Bleeds
- Persistent Cough
- Persistent Runny Nose
- Recurring Sore Throat
- Ringing in Ears
- Sinus Problems
- Vision Halos

Respiratory

- Coughing
- Coughing Up Blood
- Shortness of Breath
- Wheezing

Cardiovascular

- Chest Pains
- Irregular Heart Beat
- Circulation Problems
- Heart Palpitations
- Rapid Heartbeat
- Swelling of Ankles
- Varicose Veins

Musculoskeletal

- Back Pain
- Carpal Tunnel Syndrome
- Joint Pain
- Joint Swelling
- Neck Pain
- Shoulder Pain

Men Only

- Erection difficulties
- Lump in Testicles
- Penile Discharge
- Sore on Penis

Women Only

- Abnormal Pap Smear
- Bleeding between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge



Acknowledgement of Receipt Administrative Policies

1. I acknowledge that I have received and understand the Michigan Avenue Primary Care Follow-up Instructions, including the Xray follow-up instructions.

In summary,

I will follow up as needed with Dr. Fox, Dr. Kupkowski, Dr. Merok, Dr. Mathew, Nurse Practitioner Laura Loeser and/or the physicians at Michigan Avenue Immediate Care.

I will carefully review the precautions and warnings concerning my prescribed medications before initiating treatment.

I will follow up as needed with a health care provider if I have any questions, uncertainty or need additional assistance.

2. I acknowledge receipt of the Michigan Avenue Primary Care Notice of Privacy Practices (NPP).
3. I have read and understand the Cancellation Policy at Michigan Avenue Primary Care. I understand I will be charged \$50 for any missed appointment not cancelled or rescheduled more than 24 hours in advance.
4. I have read and understand the Michigan Avenue Primary Care Fee and Payment Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time without notification.

I authorize Michigan Avenue Primary Care to bill my insurance company for all services provided on this and all future visits. I authorize payment to the provider and understand that the processing of medical insurance is done as a courtesy and that I am ultimately responsible for payment of medical bills incurred.

I authorize the release of any medical information necessary to process this claim for health care payment only.

Signature of Patient or Guardian: _____ Date: _____

Signature of MAPC staff: _____ Date: _____