New Patient Registration Form

ExecTech

Welcome to ABC Medical Office! We look forward to giving you the best medical experience possible. Please complete both sides of this form. Let us know if you need any assistance with it.

Patient Name _____ Date _____
First Middle Last

Social Security #_____Birth Date_____ Best way to contact you?_____

Home Address _____ Home Phone _____
Street City State Zip

Mobile _____ Work Phone _____ E-mail _____

Marital Status: Single__ Married__ Divorced__ Widowed__ Spouse's Name and Phone_____

How did you learn about our practice?

❒ Recommendation from a friend or family member. If so, who may we thank? _____

❒ Recommendation from another healthcare provider. If so, who may we thank? _____

❒ Internet search ❒ Yelp ❒ Other _____

Have you visited our website (www.abc-medical.com)?Yes No

Do you have any friends or family members who may need medical care? _____

Insurance Section

Do you have medical insurance? ❒ Yes ❒ No If yes, please complete the following:

Name of Insured Person _____ Relationship to Patient _____

Birth Date _____ Social Security # _____

Name of Employer _____ Work Phone _____

Address of Employer _____

Primary Insurance Company _____ Group # _____ Union/Local # _____

Do you have additional medical insurance? ❒ Yes ❒ No If yes, please complete the following:

Name of Insured Person _____ Relationship to Patient _____

Birth Date _____ Social Security # _____

Name of Employer _____ Work Phone _____

Address of Employer _____

Secondary Insurance Company _____ Group # _____ Union/Local # _____

Emergency Contact Person _____ **Relationship** _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Person responsible for account (if not you)_____ **Relationship** _____

Employer _____Social Security #_____Birth Date_____

Home Address _____

Home Phone _____ Mobile Phone _____

Work Phone _____E-mail _____

Is this person a patient in our office? ❒ Yes ❒ No

Medical Section

Current medical problems:_____

Last physician's name and city: _____

When was your last medical visit? _____What was done then? _____

Medical Questions

1. Are you under the care of another M.D.? . . . . Yes No
Physician's Name/Phone: _____
2. Have you ever had high blood pressure? . . . . Yes No
3. Has a physician ever said you have heart trouble? . . . . . Yes No
4. Do you have Mitral Valve Prolapse? . . . . . Yes No
5. Have you ever had excessive bleeding from a cut or tooth extraction? . . . . . Yes No
6. Have you ever had an anesthetic (either local or general)? . . . . . Yes No
8. Are you allergic to penicillin or any other medication? . . . . . Yes No
If yes, please explain: _____
9. Are you allergic to anything other than medicine, such as latex rubber or metals? . . . . . Yes No
If yes, please explain _____
10. Are you pregnant? . . . . . Yes No
11. Do you have a pacemaker? . . . . . Yes No

13. Have you taken any medication or drugs in the past two years? If yes, please list them:

14. Have you gone to the hospital or emergency room or had a serious illness in the last three years? If Yes, please explain:

15. What is your daily consumption of:
Caffeinated drinks (Coffee, Tea, Sodas):
Tobacco:
Alcohol:
Pain Medicine (Aspirin, Tylenol, etc.):
Steroids:
Recreational Drugs:

16. Do you exercise on a regular basis? If so, how often and what type?

Do you have or have you ever had:

1. Heart murmur . . . . . Yes No
2. Rheumatic fever? . . . . . Yes No
3. Rheumatic heart disease? Yes No
4. Heart attack? . . . . . Yes No
5. Stroke? . . . . . Yes No
6. Epilepsy or convulsions? . Yes No
7. Fainting or dizziness? . . . . Yes No
8. Anemia or leukemia? . . . . Yes No
9. Low platelets . . . . . Yes No
10. Stomach ulcer? . . . . . Yes No
11. Cancer? . . . . . Yes No
12. Radiation therapy? . . . . . Yes No
13. Asthma or hay fever? . . . Yes No
14. Eczema or hives? . . . . . Yes No
15. Arthritis? . . . . . Yes No
16. Glaucoma? . . . . . Yes No
17. Tuberculosis? . . . . . Yes No
18. HIV / AIDS? . . . . . Yes No
19. Syphilis? . . . . . Yes No
20. Diabetes? . . . . . Yes No
21. Kidney trouble? . . . . . Yes No
22. Prostate trouble? . . . . . Yes No
23. Liver trouble or jaundice? Yes No
24. Hepatitis? . . . . . Yes No
25. Thyroid trouble or goiter? Yes No
26. Psychiatric treatment? . . Yes No

Are you now taking:

1. High blood pressure drugs?Yes No
2. Drugs for sleep? . . . . . Yes No
3. Cortisone, steroids, ACTH?Yes No
4. Anticoagulants or blood thinner? . . . . . Yes No
5. Tranquilizers or sedatives? Yes No
6. Antibiotics? . . . . . Yes No
7. Insulin? . . . . . Yes No
8. Any other drugs?_____

Have you ever been under the care of a physician for any major illness or injury other than those noted above? If so, please explain below:

1. To the best of my knowledge, I have answered every question completely and accurately. I will inform my physician of any change in my health and/or medication.
2. I agree to be responsible for all costs and fees that my insurance carrier does not pay.
3. I consent to receiving a medical examination.
4. I have received a copy of the "Notice of Privacy Practices."

Patient or Guardian Signature_____Date _____

Updates: Has anything changed since you completed this form?

	Signature	Date	Changes
Yes No			
Yes No			
Yes No			
Yes No			
Yes No			
Yes No			

Optional Questions

1. Additional General Questions

Height
Weight
Do you have a family member that sees us?

2. Additional Health Questions

Have you been hospitalized within the past two years?
Have you taken any medication or drugs in the past two years?
Is your general health good? If No, please explain:
Has there been a change in your health within the last year? If yes, please explain:
Have you gone to the hospital or emergency room or had a serious illness in the last three years? If Yes, please explain:
Are you being treated by a physician now? If Yes, please explain
Date of last medical exam?
Reason for exam:
Do you have other pain right now? If yes, please explain:
Do you wear contact lenses?
Do you use tobacco?
Have you ever taken a drug called Fen-Phen?

Have you ever had:
Abnormal bleeding
Aids/HIV
Alcoholism
Allergies
Anemia
Angina
Any type of transplant
Any type of implant
Arthritis
Artificial heart valve
Artificial joint
Bisphosphonate treatment
Bleeding problems
Blood in stools
Blood transfusion
Blood in urine
Blurred vision
Bruise easily
Cancer
Canker or cold sores
Chemotherapy
Chest pains
Cold sores
Colitis
Congenital heart defect
Cosmetic surgery
Coughing up blood
Diarrhea or constipation
Difficulty urinating
Difficulty breathing
Difficulty swallowing

Dizzy spells
Drug addiction
Dry mouth
Easily winded
Eating disorders
Emphysema
Emphysema or other lung disease
Excessive thirst
Eye disease
Facial surgery
Family history of heart disease
Family history of diabetes
Fever
Fever blisters
Frequent headaches
Frequent vomiting
Frequent urination
Frequently tired
Hardening of arteries
Headaches
Heart surgery
Heart problems
Heart disease
Hemophilia
Hepatitis
Herpes
Jaundice
Joint replacement
Joint pain or stiffness
Joint replacement
Leukemia
Low blood pressure
Lung disease
Mental retardation
Mitral valve prolapse
Nervous disorder
Night sweats
Oral herpes
Osteoporosis
Pacemaker
Persistent cough
Radiation therapy
Recent significant weight loss
Recent weight loss
Respiratory problems
Rheumatic fever
Ringing in ears
Seizures
Sexually transmitted disease
Shingles
Shortness of breath
Sickle cell disease
Sinus problems
Skin disease
Sleep apnea
STD
Steroid treatment

Surgeries
Swollen ankles
Swollen ankles
Thyroid problem
Transplants
Tumors or cancer
Ulcers
Venereal disease

Are You Allergic to or Have You Had a Reaction to Any of the Following?
Aspirin
Codeine
Darvon
Demerol
Erythromycin
Latex
Local anesthetic (Novocain or Xylocaine)
Metal
Nitrous oxide
Penicillin
Percodan
Tetracycline
Valium
Vicodin
Others

Are You Taking or Have You Taken Any of the Following in the Last Three Months?
Alcohol
Antibiotics
Aspirin
Barbiturates
Codeine
Iodine
Over-the-counter medicines
Penicillin
Recreational drugs
Sulfa
Supplements
Tobacco in any form
Weight loss medications

Female Health Questions
Are you or could you be pregnant? If Yes, what month?
Are you breast feeding?
Are you taking any form of birth control?

Additional Statement Options

Not all services are covered by insurance. In the event your insurance plan determines a service to not be covered, you will be responsible for the complete charge. Our staff cannot guarantee your eligibility and coverage. Insurance rules and limits vary with insurance plans. If your insurance plan denies a service, you will be responsible for the charge. We do not base your treatment plan on what your insurance plan covers or does not cover.

The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my own health. I authorize the physician to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such medical care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the physician or medical group insurance benefits otherwise payable to me.

A $25 fee will be charged for all appointment cancellations made without 24 hour notice.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my physician of any change in my health and/or medication. Further, I will not hold my physician, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

I hereby assign to _____ Medical any and all medical benefits otherwise payable to me for oral health treatment rendered by _____ Medical as described in the attached claim form. I acknowledge that I am still responsible for paying the above-referenced physician to the extent the relevant insurer or payer does not pay the physician in full.