carelife MEDICAL

PATIENT REGISTRATION FORM: PLEASE PRINT CLEARLY

PATIENT NAME: (LAST, FIRST, MIDDLE)	SEX ☐ M ☐ F	DATE OF BIRTH / /	SOCIAL SECURITY NO. - -	MARITAL STATUS ☐ S ☐ M ☐ SEP ☐ D ☐ W
MAILING ADDRESS			CITY / STATE / ZIP CODE	

HOME PHONE # ( ) -	WORK PHONE # ( ) - EXT:____	CELL PHONE # ( ) -	EMAIL

RACE: ☐ CAUCASIAN ☐ AFRICAN-AMER ☐ AMER.INDIAN/AK NATIVE ☐ ASIAN ☐ PACIFIC ISLANDER ☐ OTHER _____ DECLINED	HISPANIC ☐ YES ☐ NO	IF PREFERRED LANGUAGE IS NOT ENGLISH PLEASE SPECIFY:

EMPLOYER	OCCUPATION/JOB TITTLE
EMPLOYER ADDRESS	

EMMERGENCY CONTACT	RELATIONSHIP	HOME PHONE # ( ) -	CELL PHONE # ( ) -

NAME OF REFERRING PHYSICIAN OF FACILITY	NAME OF PRIMARY CARE PHYSICIAN

PREFERRED LOCAL PHARMACY: ADDRESS / LOCATION	TELEPHONE ( ) -

DO YOU HAVE MEDICAL INSURANCE? ☐ NO ☐ YES, if yes, please complete section below. Please provide your insurnce card(s) for copy.

PRIMARY INSURANCE CO. NAME		ID # OR POLICY #	GROUP #
SUSCRIBER'S NAME ☐ SELF	RELATIONSHIP TO PATIENT ☐ SELF	SUBSCRIBER'S DATE OF BIRTH SUBSCRIBER'S SOCIAL SECURITY NO.	

SECONDARY INSURANCE CO. NAME		ID # OR POLICY #	GROUP #
SUSCRIBER'S NAME ☐ SELF	RELATIONSHIP TO PATIENT ☐ SELF	SUBSCRIBER'S DATE OF BIRTH SUBSCRIBER'S SOCIAL SECURITY NO.	

TERTIARY INSURANCE CO. NAME		ID # OR POLICY #	GROUP #
SUSCRIBER'S NAME ☐ SELF	RELATIONSHIP TO PATIENT ☐ SELF	SUBSCRIBER'S DATE OF BIRTH SUBSCRIBER'S SOCIAL SECURITY NO.	

PATIENT ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby authorize *CareLife Medical PLLC* ("CLM") to apply for my medical insurance benefits for covered services rendered by CLM and hereby assign and authorize payment of such benefits directly to CLM or to the CLM provider who rendered services to me. I certify that the information I have reported to CLM with regard to my insurance coverage is true and correct and agree to notify CLM of any changes such information prior to receiving services from CLM. I authorize to CLM ro release any necessary information, including but not limited to my medical information, for purposes of furthering my medical care and for processing and receiving payment for services rendered to me, to others providers participating in my care, to my insurance carrier or its designees, or in the case of Medicare Part B benefits, to the Social Security Administration and/or the Health Care Financing Administration or their respective designees.

I have been informed and am aware of the fact that my current insurance plan may not reimburse totally the charges for services rendered by CLM. I acknowledge that I am responsible for any unpaid balances, and agree to promptly paid sald balances. I understand that should my account be submitted for collections due to nonpayment. I will responsible to all attorney and collection fees. A copy os this Authorization may be used in place of the original.

SIGNATURE: _____ DATE: _____/_____/_____

Patient, Parent, or Legal Guardian

carelife MEDICAL

Carelife Medical, PLLC.

RECEIP OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of *CareLife Medical, PLLC's*
PRINT PATIENT NAME

Notice of Privacy Practices.

_____ _____ / _____ / _____
SIGNATURE OF PATIENT DATE

RELEASE INFORMATION TO FAMILY / FRIENDS

CareLife Medical, PLLC is dedicated to maintaining the privacy of your protected health information. If you would like for us to be able to release your protected health information to another individual involved in your care (your health providers are automatically included), please provide us with his/her contact infomration below. This individual may be your spouse, a family member, or friend with whom we may discuss your information (examples: diagnosis, diagnostic results, medications, treatments, etc.).

(1) _____ / _____
PRINT NAME RELATIONSHIP

Home	( )
Work	( )
Cell	( )

(2) _____ / _____
PRINT NAME RELATIONSHIP

Home	( )
Work	( )
Cell	( )

For Office Use: ☐ Emergency Contact does NOT know diagnosis. Please do NOT disclose.

carelife
MEDICAL

Date of Appointment:
____/____/____

PATIENT NAME: (LAST, FIRST, MIDDLE)	Gender	Age	Date of Birth ____/____/____

Reason for your Visit

What brings you to the office today?
Illness _____

How is your general health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medication

What medication are you currently taking?

Name	Dossage	Frequency

Allergies

Are you allergic to any of the following:

☐ Adhesive tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Local Anesthetics ☐ Codeine ☐ Sulfa

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems ☐ Hepatitis A, B, or C ☐ Measles ☐ Skin Disorder
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder ☐ High Blood Presure ☐ Migraines ☐ Stomach Ulcer
☐ Anemia ☐ Blood Disease ☐ Epilepsy ☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma ☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Arthritis ☐ Cancer ☐ Gout ☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ AIDS/HIV ☐ Depression ☐ Heart Problems ☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Women Only

# of Pregnacies # of Miscarriages # of Abortions # of Living

Last PAP Smear Last Mammogram Birth Control Method

Family History

Has anyone in your family had any of the following conditions?
Please indicate which family member hast the following:
GF - Grandfather GM - Grandmother M - Mother F - Father S - Sibling

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disease
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxietyr ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Osteoporosis
☐ Asthma ☐ AIDS / HIV ☐ Heart Disease

☐ Psychiatric Disorders ☐ Hepatitis
☐ Bleeding Disorder ☐ High Cholesterol
☐ Substance Abuse ☐ High Blood Pressure
☐ Blood Disorder ☐ Thyroid Disorder
☐ Stroke

Health Exams and Procedures

Please check and date the last time you had each exam or procedure performed:

☐ Cholesterol Test _____ ☐ MRI _____
☐ Colonoscopy _____ ☐ Physical Exam _____
☐ CT / CTA Scan _____ ☐ Ultrasound _____
☐ EKG _____ ☐ Echocardiogram _____
☐ Cardiac Stress Test _____

Immunizations

☐ Hepatitis A _____ ☐ Meningitis _____
☐ Hepatitis B _____ ☐ HPV Vaccine _____
☐ Hepatitis C _____ ☐ Polio _____
☐ Pneumonia _____ ☐ Tetanus _____
☐ Influenza (Flu shot) _____ ☐ MMR* _____
(measles, mumps, rubella)

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Date of Appointment:
____/____/____

PATIENT NAME: (LAST, FIRST, MIDDLE)	Gender	Age	Date of Birth ____/____/____

Review of Systems

General
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth - Excessive
- ☐ Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst - Excessive
- ☐ Weight Gain
- ☐ Wirght 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
- ☐ Changes in Moles
- ☐ Chills
- ☐ Dry / Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sore That Won't Heal

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

Genitourinary
- ☐ Blood 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
- ☐ Tremore

ENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ HayFever
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Presistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Halos

Women Only
- ☐ Abnormal PAP Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Vaginal Discharge

Men Only
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penile Discharge
- ☐ Sore on Penis

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

Respiratory
- ☐ Coughing
- ☐ Coiughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

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

Other Symptoms: _____

_____

_____

_____

Liestyle Factors

Occupation: _____

Marital Status: _____

Are you sexually active? ☐ Yes ☐ No # of partners in past year _____

Do you have sex with Men, Women, or both? _____ # of lifetime partners _____

Have you ever smoked? ☐ Yes ☐ No Do you smoke now? ☐ Yes ☐ No # Pack/day _____

Do you use recreation drugs? ☐ Yes ☐ No Types? _____ # times/week _____

How much alcohol do you drink per week? # drinks/week _____

How much caffeine do you drink per day? # drinks/day _____

How often do you excercise? # times/week _____

PLACE OF BIRTH: _____

TRAVELS ABROAD: _____

_____

_____

_____