Alejandro Posada, MD

PATIENT REGISTRATION FORM

|  |  |  |
| --- | --- | --- |
| Last name | First name | Middle initial |
| SEX Male □ Female □ | Date of birth | Marital Status |
| Street address | City | State | Zip |
| Home phone number | Mobile number | Work number |
| Email address |  |
| How did you hear about her officeInternet □ Previous Patient □ Insurance Company □ Friend/Relative □ Physician □ |
| RaceAmerican Indian □ Asian/Oriental □ Black/African-American □ White □ Other □ |
| Primary Care Physician |
| Last name | First name |
| Pharmacy name | Pharmacy phone number |
| Pharmacy address |
| Employer information |
| Occupation | Employer name |
| Insurance information |
| Insurance plan name | Insurance phone number | Policy ID |
| Street address for claims | City | State | Zip |
| Patient relationship to policyholder | Policyholder date of birth |
| Policyholder last name | Policyholder first name | Middle initial |
| Emergency contact information |
| Last name | First name | Middle initial |
| Phone number | Relationship to patient |
| Guardian information (if applicable) |
| Last name | First name | Middle initial |
| Street address | City | State | Zip |
| For workers compensation cases only |
| Date of injury | Workers compensation claim number |
| Case manager/Adjuster’s name | Case manager/adjuster’s phone number |
|  |
| Reason for your visit |
| Where is the problem? (Shoulder, knee, etc.) Space Which side (right, left)? |
| When did you first experience problems? (Please give approximate date) |
| If you had an injury, please describe (include date of injury) |
| Describe your problem |
|  | YES | NO |
| Is this case involved in litigation or will it be involved in litigation? |  |  |
| Is this a workers compensation injury? |  |  |
| Have you had x-rays? |  |  |
| Have you had an MRI? |  |  |

PAST MEDICAL HISTORY

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| --- |
| Past surgical history |
| Surgery | Reason | Year |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| ALLERGIES/sensitivities to medication/reaction |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
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| Past medical history |
|  | Yes | No |  | Yes | No |  | Yes | No |
| Allergies |  |  | Diabetes |  |  | Lung disease |  |  |
| Anemia |  |  | Diabetic complications |  |  | Mental disorder |  |  |
| Anxiety |  |  | Endocrine disease |  |  | Movement disorder |  |  |
| Arthritis asthma |  |  | Eye problems |  |  | Nerve disease |  |  |
| Autoimmune disease |  |  | Gastritis/ulcer |  |  | Osteoporosis/osteopenia |  |  |
| Back pain |  |  | GERD/acid reflux |  |  | Obesity/overweight |  |  |
| Blood disorder |  |  | Headaches/migraines |  |  | Pneumonia |  |  |
| Bowel disease |  |  | Hearing loss |  |  | Prostate cancer |  |  |
| CAD |  |  | Heart rhythm disorder |  |  | Spine disease |  |  |
| CHF |  |  | Heart disease |  |  | Stroke/TIA |  |  |
| COPD |  |  | Hypertension |  |  | Thyroid disease |  |  |
| Cancer |  |  | Hyperlipidemia |  |  | Tuberculosis/positive PPD |  |  |
| Dementia |  |  | Kidney disease/stones |  |  | Urinary problems |  |  |
| Developmental |  |  | Liver disease |  |  | Viral disease |  |  |
| Depression |  |  |  |  |  |  |  |  |
| Other |
| Family Health History |
| Relationship | Age of onset | Significant health problems |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| MEDICATIONS |
| Name of medication | Dose | Frequency taken |
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| SOCIAL HISTORY |
| Do you smoke tobacco, if so how much? |
| Do you drink caffeine, if so how much? |
| Do you currently use recreational or street drugs? If so which one? |
| Do you have a history of drug abuse? |

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_