

# NEW PATIENT REGISTRATION

Date: \_\_\_\_\_

<b>PATIENT INFORMATION</b>	Name (Last)		(First)	(MI)	Home Phone (Area Code) ( )		
	Home Address					APT. #	
	City		State		Zip Code		
	Mailing Address if different from above						
	City		State		Zip Code		
	If visiting the Tampa Bay area – please give address and telephone number where you are staying.					First Visit to the Clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Date of Birth		Sex M F		PATIENT STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other		Social Security No.
	<input type="checkbox"/> Employed <input type="checkbox"/> Leased Employee		Employed by		Occupation		
	<input type="checkbox"/> Part-Time Student <input type="checkbox"/> Full-Time Student						
Employer's Address				Work Phone No. ( )			
<b>REASON FOR VISIT</b>							
<b>IF AN ACCIDENT</b>	When did accident happen			Where did accident happen			
	If Workers Comp – Did you Notify Your Employer?						
<b>METHOD OF PAYMENT</b>	<input type="checkbox"/> CHECK (Provide copy of Drivers License)		<input type="checkbox"/> EMPLOYER		<input type="checkbox"/> WORKER'S COMP. INSURANCE Verification Required		
	<input type="checkbox"/> CASH		<input type="checkbox"/> MEDICARE		<input type="checkbox"/> MEDICAL INSURANCE		
	<input type="checkbox"/> CREDIT CARD		<input type="checkbox"/> HMO NAME: _____		<input type="checkbox"/> PPO NAME: _____		
<b>RESPONSIBLE PARTY INFORMATION</b>	Your Relation to Patient		Name		Street Address		
	City		State		Zip Code		
	Home Phone (Area Code) ( )		Date of Birth		Sex <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
	Social Security No.		Employer's Address		Employer's Phone #		

## AUTHORIZATION AND AGREEMENT FOR MEDICAL TREATMENT

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGEMENTS AND AGREEMENTS REGARDING THE MEDICAL TREATMENT TO BE PROVIDED THE PATIENT WHOSE NAME APPEARS ON THIS FORM HEREOF:

**AGREEMENT TO PAY SERVICES**

1. For and in consideration of the care and treatment provided to the patient, I promise to pay \_\_\_\_\_ all charges for services rendered to or in behalf of the patient.
2. I hereby authorize \_\_\_\_\_ to release any medical information in connection with these services for health insurance purposes or to the patient's personal physician.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE ABOVE, AND IS THE PATIENT, GUARANTOR, OR THE PATIENT'S REPRESENTATIVE DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS:

DATE: \_\_\_\_\_ **X** \_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Representative Name (Print) Telephone Permission for Minor Granted By: \_\_\_\_\_  
\_\_\_\_\_  
Representative's Relationship \_\_\_\_\_  
\_\_\_\_\_  
Witness \_\_\_\_\_  
Reason for Representative Signatures \_\_\_\_\_

**PERSONAL HEALTH HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

**Please check any of the following medical conditions you have or have had:**

	Yes	No		Yes	No
Anemia / Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils / Adenoids / Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Asthma / Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis / Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	TB / History of Positive Skin Test	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Consciousness / Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Seizures / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis / Liver Disease / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Neck / Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease / Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Cancer / Tumor / Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease / Goiter	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Knee or Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>
Color Blindness / Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke / Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease / Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Deafness / Hearing Loss / Ringing in the Ears	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer / Digestive Problem / Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems / Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>	History of Alcohol or Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Immune Deficiency Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Gyn. (female) Problems / Infections	<input type="checkbox"/>	<input type="checkbox"/>
Removal of Spleen	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy / Gyn. (female) Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers / Stomach Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Hernia Repair	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Rectal / Bowel Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Breast Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Major Bone / Joint Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Heart / Lung Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cataract Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>

**Please list any other medical / surgical condition, or comment on any of the above:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PERSONAL HEALTH HABITS**

Do you smoke? YES  NO  How Much? \_\_\_\_\_ How Long? (years) \_\_\_\_\_ Cigarettes  Cigars  Pipe

Do you drink alcoholic beverages? YES  NO  What kind? \_\_\_\_\_ How often? \_\_\_\_\_

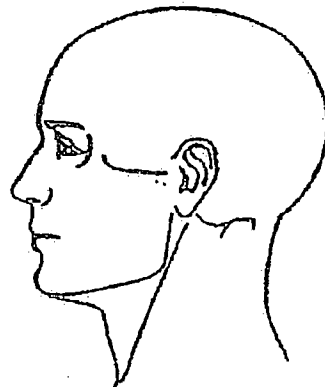
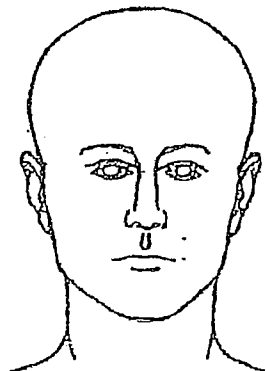
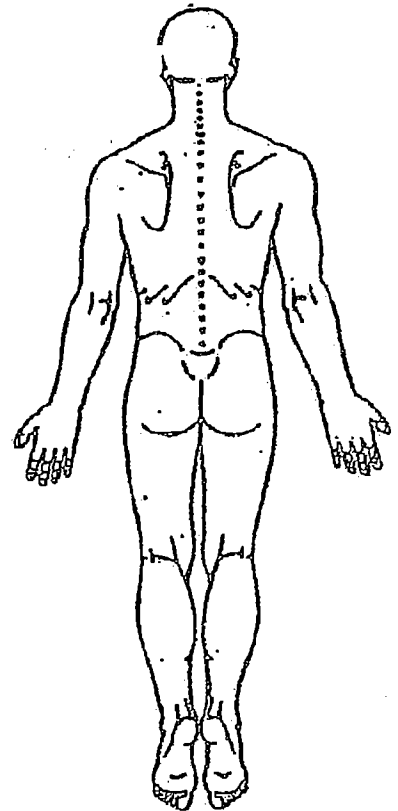
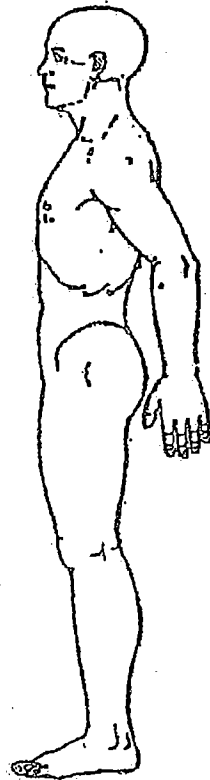
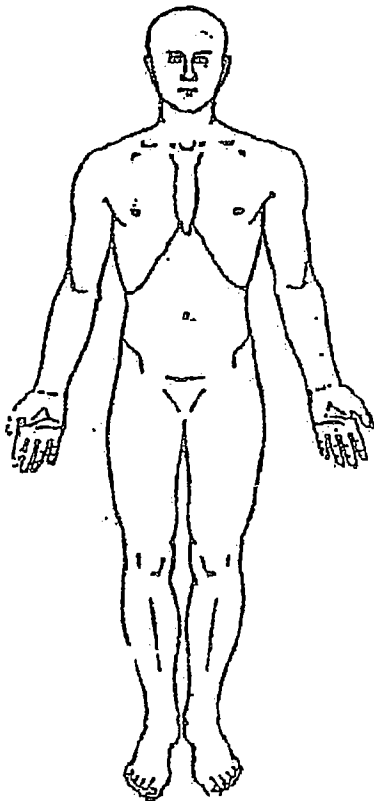
**FOR FEMALES ONLY**

Are you pregnant? YES  NO  Date of last menstrual cycle? \_\_\_\_\_

X \_\_\_\_\_  
Signature of person completing Health History

# CONFIDENTIAL CASE HISTORY

PLEASE CIRCLE OR MARK ANY AREA OF PAIN OR CONCERN



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