Eastside Medical Group
Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr./Sr.

Patient's Name (Last) _____ (First) _____ (MI) ____ Previous Name _____

Address _____

City, State _____ ZIP_____

Home Phone _____ Cell No. _____ Work Phone _____Ext. _____

E-Mail Address:_____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Social Security Number ___-___-____

Race/Ethnicity ☐Asian ☐ Black or African American ☐ Caucasian ☐ Hispanic or Latino
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Declined

Language ☐ English ☐ Spanish ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Primary Care Provider (PCP) _____ Referring Provider _____

Pharmacy _____ Pharmacy Phone_____

Employer Name _____Employer Phone _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Relationship to Patient _____

Do you have a living will? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

☐ Self

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Date of Birth MM ____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____

(If different from patient) Address _____City, State _____ ZIP ___

Employer _____ Employer Phone Number_____

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Primary Insurance _____Insured _____DOB_____

Secondary Insurance _____Insured _____DOB_____

How did you hear about us?

☐ Website ☐ Internet Search ☐ Internet Advertisement ☐ Family/Friends ☐ Facebook ☐ Magazine/Newspaper Ad

☐ Another healthcare provider: _____ ☐ Physician Directory ☐ Hospital MD Referral – Medline

Eastside Medical Group: DATE:_____

Name: _____ Date of Birth: _____Age: _____
Male / Female (circle one) Pregnant Yes / No (circle one)

Reason you are here: _____

SOCIAL HISTORY

_____

Marital Status: □ Single □ Married □ Partner □ Divorced □ Widow/Widower
Children _____ Occupation/Job _____Religion_____

HABITS

_____

Do you dip or chew tobacco? □ Yes □ No If yes, how much per day? _____
Smoking:
□ Never smoked □ Former smoker Date Quit_____□ Current smoker / How Long? _____Packs per day?_____
Do you drink alcoholic beverages? If yes, how many per week? _____
Do you drink beverages that contain caffeine: (coffee, tea, soda) _____ cups per day
Do you use recreational drugs? If yes, what and how often? _____

CURRENT MEDICATIONS:
Include herbal and over-the-counter drugs. List and name dose. Using additional sheet if needed.
(If you brought a medication list or brought your medications DO NOT FILL OUT)

_____

1. _____ 5._____

2._____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

MEDICATION ALLERGIES: □ **No medication allergies**

Are you allergic to latex? □ Yes □ No

PAST MEDICAL HISTORY

Please check below if you have, or have had any of the following medical conditions **□ No Past medical problems**

□ Acid reflux
□ Adverse reaction to anesthesia
□ Alzheimer's significant memory loss
□ Anemia
□ Angina or chest pain
□ Arthritis
□ Asthma
□ Atrial fibrillation or erratic heartbeat
□ Bleeding problems
□ Blood transfusion
□ Blood clot in leg(s) or lung(s)
□ Bruise easily
□ Cancer Type: _____
□ Thyroid Disease
□ Other not listed, explain:

□ Congestive heart failure
□ Dental disease
□ Depression
□ Diabetes
□ Emphysema
□ Epilepsy/Seizures
□ Fibromyalgia
□ Gallbladder disease
□ Gout
□ Heart disease
□ Hemophilia / Excessive bleeding
□ Hepatitis
□ High blood pressure / Hypertension
□ High cholesterol
□ Tuberculosis

□ HIV or Aids
□ Infections: _____
□ Kidney/Bladder disease
□ Leg pain
□ Lung disease
□ Osteoporosis
□ Peripheral vascular disease
□ Pneumonia
□ Psychiatric disorder
□ Rheumatoid arthritis
□ Sickle cell
□ Sleep apnea / CPAP machine
□ Stroke

FAMILY HISTORY

Please check below if Mother, Father, Siblings have had any of the following: ☐ **No family medical history to report**

	Who		Who
☐ Adverse reaction to anesthesia	_____	☐ Blood clots/Pulmonary embolism	_____
☐ Bleeding disorders	_____	☐ Cancer Type & Age	_____
☐ Depression	_____	☐ Osteoporosis	_____
☐ Diabetes	_____	☐ Rheumatoid Arthritis	_____
☐ Heart Disease (age at first event)	_____	☐ Stroke (age at first event)	_____
☐ Hypertension	_____		

SURGICAL HISTORY

Please check below if you have had any of these surgeries ☐ **No Previous Surgeries**

	Year		Year		Year
☐ Aneurysm – Abdominal	_____	☐ Colon surgery	_____	☐ Open heart surgery	_____
☐ Angioplasty / stents	_____	☐ Fistula R or L	_____	☐ Pacemaker/Defibrillator	_____
☐ Appendectomy	_____	☐ Gallbladder	_____	☐ Prostate surgery	_____
☐ Artery bypass of arm/ leg	_____	☐ Gastric bypass surgery	_____	☐ Spine surgery	_____
☐ Breast surgery	_____	☐ Heart stents	_____	☐ Tonsils	_____
☐ Caesarean section	_____	☐ Hernia surgery where	_____	☐ Total hip / knee	_____
☐ Carotid surgery	_____	☐ Hysterectomy	_____	☐ Other not listed, explain:	_____
☐ Cataract surgery	_____	☐ Nasal surgery	_____		

HOSPITALIZATIONS ☐ No Past Hospitalizations

Date: (Mo/Yr)	Reason
_____	_____
_____	_____
_____	_____

GYN HISTORY

	Year			Year
☐ LMB	_____		☐ Last PAP Smear (date)	_____
☐ Last Mammogram (date)	_____		☐ Last Dexascan (date)	_____
☐ Hx of Abnormal PAP smear		☐ **Yes** ☐ **No**		
☐ STD	_____	☐ **Yes** ☐ **No**		
☐ Birth Control	_____	☐ **Yes** ☐ **No**		

To Be Filled Out By Nurse ☐ Review of symptoms negative

HEIGHT: _____ WEIGHT: _____ TEMP: _____ PULSE: _____ O2 SAT: _____

BP RIGHT ARM: _____ BP LEFT ARM: _____

FLU SHOT: _____ Date: _____

Diagnosis _____