



## New Patient Registration

Today's Date

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Name

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Address

---

City

State

Zip

---

Home Phone (       )

Work/Mobile Phone (       )

---

Email Address

---

Social Security Number

---

Age

Date of Birth

Marital Status

Single    Married    Widowed  
 Separated    Divorced

---

Emergency Contact Name

Phone (       )

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Primary Care Doctor (If Any)

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## Employment

Occupation

Employer

---

Work Address

---

City

State

Zip

---

## Referring Information

How Did You Hear About Us? (Check one or more)

Your Doctor   Name

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Friend/Relative    Current Patient    Yellow Pages    Internet

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Other   Please Specify

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## Insurance Information

### Primary Insurance

Company

---

Name of Policy Holder

Policy Holder Date of Birth

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Policy/ID Number

Group Number

---

### Secondary Insurance

Company

---

Name of Policy Holder

Policy Holder Date of Birth

---

Policy/ID Number

Group Number

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## NOTICE

We will file your insurance for the companies with whom we are contracted. You will be responsible for any co-payments or deductibles at the time services are rendered. If you have insurance with a company with who we have no contract, we will file your insurance for any charges over \$200. You will be responsible for co-payments, deductibles, out of network amounts, or any portion for your insurance company deems you responsible.

We allow your insurance company 45 days to pay your claim. If we do not receive payment within 45 days, you will receive a bill at that time. For our HMO/PPO patients, if we are contracted with your HMO/PPO, you will not receive a bill until we have heard from your insurance company. If you have any questions regarding your insurance, please ask to speak with our insurance specialist, Irene Schuttler.

## New Patient Medical Information

Reason For Today's Visit

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**Past Medical History** (Check all that apply)

High Blood Pressure    Heart Attack    Heart Disease    Stroke    Diabetes    Asthma

Prostate Disease (Please Specify)

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Bladder Condition (Please Specify)

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Cancer (Please Specify)

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Lung Disease    Ulcer Disease    Bowel Disease    Kidney Disease

Other (Please Specify)

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**Past Surgical History** (Check all that apply and include year of operation)

Appendectomy    Tonsilectomy    Gall Bladder    Heart Bypass

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Heart Stent    Heart Valve    Pacemaker    Hernia    Bowel Surgery

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Hysterectomy    Kidney Stone Surgery    Bladder Surgery    Prostate Surgery

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**Other** (Please Specify)

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## List All Current Medications

Name

Dosage

How Often Taken

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Any over the counter medications? \_\_\_\_\_

Herbal supplement, vitamins? \_\_\_\_\_

Coumadin/Warfarin or other blood thinner? \_\_\_\_\_

Daily Aspirin? Other anti-inflammatory medication? \_\_\_\_\_

Do you have allergies to any medication? \_\_\_\_\_

## Social History

Cigarettes?  Yes  No If yes, how much? \_\_\_\_\_

Cigars/pipes?  Yes  No If yes, how much? \_\_\_\_\_

Chewing tobacco?  Yes  No If yes, how much? \_\_\_\_\_

Do you use alcohol?  Yes  No If yes, how much? \_\_\_\_\_

Do you use illicit drugs?  Yes  No If yes, how much? \_\_\_\_\_

## Family History

Of Prostate Cancer?  Yes  No \_\_\_\_\_

Of Kidney Stones?  Yes  No \_\_\_\_\_

Other?  Yes  No If yes, please specify \_\_\_\_\_

## Review of Other Medical Systems (Check all that apply)

Fever, Chills, Weight Loss?

Blurred Vision?

Headaches?

Nasal Discharge or Sore Throat?

Heart Murmurs, Chest Pain?

Cold or Swollen Legs?

Cough, Shortness of Breath, Wheeze?

Nausea, Vomiting, Heartburn, Diarrhea, Constipation?

Black Stool or Blood Per Rectum?

Neck, Joint, or Back Pain?

New Skin Rashes or Discoloration?

Seizures?



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