Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian | Date

Name: _____ Age: _____ Gender: _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

Date symptoms started _____

Have you lost any days from work or school? ☐ Yes ☐ No

Do you have any:

- ☐ Lower Back or Side Pain
- ☐ Bed Wetting
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Difficulty Maintaining an Erection
- ☐ Painful Intercourse
- ☐ Excessively Frequent Urination
- ☐ Inability to Urinate
- ☐ Loss of Bladder Control/ Urinary Incontinence
- ☐ Loss of Bowel Control/ Fecal Incontinence
- ☐ Vaginal Discharge
- ☐ Loss of Urine when Coughing, Sneezing, Bearing Down, Changing Position
- ☐ Waking up at Night to Urinate
  # of times _____
- ☐ Pain with Urination

Medications

What medications are you currently taking? (Include aspirin, other blood thinners, vitamins, minerals, birth control pills, hormones, herbals, supplements)

Name	Dosage	Frequency

Family History

Has anyone in your family ever had any of the following conditions?

- ☐ Cancer Type _____
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ None of the Above
- ☐ Not Sure

Details: _____

_____

Allergies

Are you allergic to any of the following?

- ☐ ACE Inhibitors
- ☐ Adhesive Tape
- ☐ Anesthetics
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ NSAIDs
- ☐ Penicillin
- ☐ Seizure Medicines
- ☐ Sulfa

Details/Reactions:

_____

_____

Past Medical History

Have you ever had any of the following?

- ☐ Anemia
- ☐ Anxiety
- ☐ Back Pain
- ☐ Bleeding Disorder
- ☐ Brain Tumor
- ☐ Hydrocephalus
- ☐ Cancer Type _____
- ☐ Chronic Fatigue
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Bladder Infections
- ☐ Gout
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Neurological Disorder
- ☐ Parasites
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Pelvic Prolapse
- ☐ Renal Failure
- ☐ Sexually Transmitted Infection
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other: _____

For Men:

- ☐ Circumcision
- ☐ Elevated PSA
- ☐ Enlarged prostate (BPH)
- ☐ Erectile Dysfunction
- ☐ Hypogonadism (Low Testosterone)
- ☐ Decreased Libido
- ☐ Premature Ejaculation
- ☐ Prostate Biopsy
- ☐ Prostatectomy
- ☐ Vasectomy

For Women:

Number of Pregnancies: _____

Number of Miscarriages: _____

Number of Abortions: _____

Number of Living Children: _____

Number of Vaginal Deliveries: _____

Date of Last Menstrual Period: _____

Hysterectomy: ☐ Yes ☐ No

Type of contraception used:

- ☐ Condoms
- ☐ Pills
- ☐ Patch
- ☐ Ring
- ☐ Shot
- ☐ Device under skin
- ☐ IUD
- ☐ Vasectomy
- ☐ Tubal ligation
- ☐ Not applicable

Hospitalizations & Surgeries

Reason	Date