

# 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		
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## 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

### 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:

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

### Medications

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

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

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?

- |   |                                  |  |
|---|----------------------------------|--|
| <input type="checkbox"/> ACE Inhibitors | <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin        |
| <input type="checkbox"/> Adhesive Tape  | <input type="checkbox"/> Iodine  | <input type="checkbox"/> Seizure Medicines |
| <input type="checkbox"/> Anesthetics    | <input type="checkbox"/> Latex   | <input type="checkbox"/> Sulfa             |
| <input type="checkbox"/> Aspirin        | <input type="checkbox"/> NSAIDs  |  |

Details/Reactions:

\_\_\_\_\_

\_\_\_\_\_

### Past Medical History

Have you ever had any of the following?

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

For Men:

- |  |  |
|--|--|
| <input type="checkbox"/> Circumcision                    | <input type="checkbox"/> Premature Ejaculation |
| <input type="checkbox"/> Elevated PSA                    | <input type="checkbox"/> Prostate Biopsy       |
| <input type="checkbox"/> Enlarged prostate (BPH)         | <input type="checkbox"/> Prostatectomy         |
| <input type="checkbox"/> Erectile Dysfunction            | <input type="checkbox"/> Vasectomy             |
| <input type="checkbox"/> Hypogonadism (Low Testosterone) |  |
| <input type="checkbox"/> Decreased Libido                |  |

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:

- |                                  |  |
|----------------------------------|--|
| <input type="checkbox"/> Condoms | <input type="checkbox"/> Device under skin |
| <input type="checkbox"/> Pills   | <input type="checkbox"/> IUD               |
| <input type="checkbox"/> Patch   | <input type="checkbox"/> Vasectomy         |
| <input type="checkbox"/> Ring    | <input type="checkbox"/> Tubal ligation    |
| <input type="checkbox"/> Shot    | <input type="checkbox"/> Not applicable    |

### Hospitalizations & Surgeries

Reason \_\_\_\_\_ Date \_\_\_\_\_

Reason \_\_\_\_\_ Date \_\_\_\_\_

Reason \_\_\_\_\_ Date \_\_\_\_\_