Initial Patient Registration Form

Legal First Name:__________________ **Middle Init:** ________________ **Last Name:** ____________________

Preferred Name: ______________________________

SSN: _________________________ **Date of Birth:** _____________

Address: _________________________ **City:** ____________________ **State:** __________________

Parish: __________________________ **Zip Code:**________________

***Email Address:**_______________________________________

Home Phone: ____________________ **Cell Phone:** ___________________________

Emergency Contact:__________________ **Emergency Contact Phone Number:**____________________________

Insurance: _____________________ **Member ID:** ___________________ **Group #:** ______________________

If Uninsured would you like to apply for Medicaid? Yes No

Please note that if you are uninsured and you chose not to apply for Medicaid **you will be responsible for the charges for your medical visit today**. Also, please note that being uninsured puts you at risk for tax penalties per the Affordable Care Act.

Employed: Yes No **Employer Name:**_________________

Income: _____________ **Frequency** (circle one): weekly bi-weekly monthly annually

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Please Circle your answers:

Gender: M F Trans **Sexual Orientation:** Heterosexual Homosexual Bisexual

Marital Staus (circle one): Married Divorced Widowed Single Legally Separated

Race: Asian Black Pacific Islander American Indian White More than 1 race Decline to answer

Homeless: Yes No **Homeless Type (circle one):** Shelter Transitional Doubling Up Street Other

Do you receive public housing assistance: Yes No

Veteran: Yes No

Preferred Language:______________________

Do you need a translator for today's visit: Yes No

Do you have the following barriers: Hearing impaired Vision impaired Reading impaired

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Please complete the following information for today's visit.

Do you have the following barriers: Hearing impaired Vision impaired

Do you need a translator for today's visit: Yes No

Tobacco Use: No Yes Recently quit

Do you wish to quit smoking? Yes No Would you like information on smoking cessation at this visit? Yes No

Do you have a past medical history of any of the following – Select all that apply:

__Diabetes __Seizure Disorder __Migraines

__Cancer: ___________ __Thyroid Disorder __Seasonal Allergies

__High Blood Pressure __Anemia __Depression

__High Cholesterol __Hepatitis __Anxiety

__Gastric Reflux __HIV __Bipolar

Please list your allergies below:

None Meds: _______________________________________ Food: ____

What is the reason for your visit today?____

Symptoms include: ____

When did they start? _________________________ **Do you have symptoms today?** Yes No

Have you seen another healthcare professional for this complaint? Yes No

Have you had any Surgeries s? Yes No

If yes, please explain when and why:____

Current Medications:

Medication	**Amount** (mg, oz., etc.)	**Frequency** (twice/day, once/week, etc.)