Primary Care Clinic

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NEW PATIENT REGISTRATION FORM					
Last Name:	First Name:		MI:	Date of Birth:	
Address:	City:		State:	Zip:	
SSN:	Age:	Cell Number:		Alt Number:	
Gender:	Employer:		Pharmacy:		
Email:					
Marital Status: O Single O Married O Divorced O Widowed O Separated O Domestic Partner				Race/Ethnicity:	

INSURANCE INFORMATION		
Primary Insurance:	Member ID:	Group Number:
Guarantor's (Responsible Party) Last Name:	First Name:	
Date of Birth:	Relationship to Patient:	
Secondary Insurance:	Member ID:	Group Number:
Guarantor's Last Name:	First Name:	
Date of Birth:	Relationship to Patient:	

EMERGENCY CONTACT INFORMATION			
Last Name:	First Name:	Relationship:	Phone Number:
Last Name:	First Name:	Relationship:	Phone Number:

PATIENT STATEMENT
I hereby grant my permission for SoCO Primary Care Clinic and its employees to provide medical care for me. I understand that I am financially responsible for my medical care whether paid by insurance or not and I hereby authorize SoCO Primary Care Clinic to release all information necessary for my treatment and to bill and receive payment. I acknowledge that I may ask to receive a copy of SoCO Primary Care Clinic's Privacy Practices. I understand that my PDMP will be pulled and reviewed prior to being scheduled for an appointment or placed on a waiting list.

Patient/Guardian Signature:_____ Date:_____

NEW PATIENT HISTORY – Please check any conditions that you have experienced past or present.	
☐ ADHD	☐ Hepatitis/Liver Disease (Specify_____)
☐ Alcoholism	☐ Hiatal Hernia
☐ Allergies	☐ High Blood Pressure
☐ Anemia	☐ High Cholesterol
☐ Anxiety	☐ HIV
☐ Arrhythmia (Irregular Heart Beat)	☐ Incontinence (Specify Bowel or Bladder)
☐ Arthritis	☐ Irritable Bowel Syndrome (IBS)
☐ Asthma	☐ Kidney Disease
☐ Atrial Fibrillation	☐ Kidney Stones
☐ Benign Prostatic Hypertrophy	☐ Learning Disorder (Specify_____)
☐ Bipolar Disorder	☐ Lupus
☐ Bleeding/Clotting Disorders	☐ Multiple Sclerosis
☐ Cancer (Specify_____)	☐ Neuropathy
☐ Chest Pain	☐ Obesity
☐ Chronic Pain (Specify_____)	☐ Osteoarthritis
☐ COPD/Emphysema	☐ Osteopenia/Osteoporosis
☐ Dementia	☐ Parkinson's Disease
☐ Depression	☐ Peripheral Vascular Disease
☐ Diabetes (Specify Type 1 or Type 2)	☐ Psoriasis
☐ Diverticulitis	☐ Pulmonary Embolism
☐ DVT (Blood Clot)	☐ Rheumatoid Arthritis
☐ Edema	☐ Seizure Disorder
☐ Gastroparesis	☐ Sleep Apnea
☐ GERD (Acid Reflux)	☐ STD (Specify_____)
☐ Glaucoma/Macular Degeneration	☐ Stroke
☐ Headache (Specify_____)	☐ Thyroid Disorder (Specify_____)
☐ Heart Attack (MI)	☐ Visual Disorder
☐ Heart Disease	☐ Other:

MEDICATION & FOOD ALLERGIES: List all known allergies (food, drugs, animals) and reactions.	
☐ No Known Allergies	
Allergy:	**Reaction:**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

SURGICAL HISTORY: List all prior surgeries, approximate dates performed, and doctor if known.

☐ No Prior Surgeries

Surgery:	Date:	Doctor:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

MEDICATIONS – List all medications you take (prescription, supplements, vitamins, the dosage, frequency, and reason for taking the medication.

☐ I Do Not Take Any Medications or Supplements

Medication	Dose	Frequency	Reason for Medication
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.
5.	5.	5.	5.
6.	6.	6.	6.
7.	7.	7.	7.
8.	8.	8.	8.
9.	9.	9.	9.
10.	10.	10.	10.
11.	11.	11.	11.
12.	12.	12.	12.
13.	13.	13.	13.
14.	14.	14.	14.
15.	15.	15.	15.

PREVENTATIVE HEALTH – Check if you have received the following and date of the most recent exam.

Exam:	Result:	Date:
O Cardiac Stress Test	O Normal O Abnormal	
O Colonoscopy	O Normal O Abnormal	
O DEXA Scan	O Normal O Abnormal	
O Echocardiogram	O Normal O Abnormal	
O EKG	O Normal O Abnormal	
O Eye Exam	O Normal O Abnormal	
O Diabetic Foot Exam	O Normal O Abnormal	
O Influenza Vaccine	O Normal O Abnormal	
O Mammogram	O Normal O Abnormal	
O PAP Exam	O Normal O Abnormal	
O Physical Exam (Annual)	O Normal O Abnormal	
O Pneumonia Vaccine	O Normal O Abnormal	
O Pulmonary Function Test	O Normal O Abnormal	
O Tetanus Vaccine	O Normal O Abnormal	

FAMILY HISTORY – Check if any family member(s) have had any of the following conditions.					
Diagnosis:	**Mother**	**Father**	**Sister**	**Brother**	**Other (Specify)**
Alcoholism	O	O	O	0	O
Anxiety	O	O	O	O	O
Arrhythmia	O	O	O	O	O
Asthma	O	O	O	O	O
Bipolar Disorder	O	O	O	O	O
Bleeding Disorder	O	O	O	O	O
Cancer (Type:_____)	O	O	O	O	O
Dementia	O	O	O	O	O
Depression	O	O	O	O	O
Diabetes (Type 1 or Type 2)	O	O	O	O	O
Heart Disease/Heart Attack	O	O	O	O	O
High Blood Pressure	O	O	O	O	O
High Cholesterol	O	O	O	O	O
Kidney Disease	O	O	O	O	O
Lupus/Rheumatoid Arthritis	O	O	O	O	O
Obesity	O	O	O	O	O
Osteoarthritis	O	O	O	O	O
Osteoporosis	O	O	O	O	O
Sleep Apnea	O	O	O	O	O
Stroke	O	O	O	O	O
Thyroid Disorder	O	O	O	O	O
Other:_____.	O	O	O	O	O
Other:_____.	O	O	O	O	O

SOCIAL HISTORY (ADULT)				
Occupation:		Employer:		
Are you Pregnant? O Yes O No	Do you have children? O Yes O No	How Many?	Male(s)?	Female(s)
Tobacco Use O Yes O No	O Daily O Weekly O Less O Former/Quit Year_____.	O Chewing O Cigarette O Cigar O Smokeless/E-Cigarette		
Alcohol Use O Yes O No	O Daily O Weekly O Less O Former/Quit Year_____.	O Beer O Wine O Liquor O Other:_____.		
Caffeine Use O Yes O No	O Daily O Weekly O Less O Former/Quit Year_____.	O Chocolate O Soda O Tea O Tablet O Coffee		

SOCIAL HISTORY (CHILD)				
Primary Residence:	O Mother	O Father	O Both Parents	O Other:
Secondary Residence:	O Mother	O Father		O Other:

Mothers Occupation:	Fathers Occupation:
Parent's Relationship: O Married O Divorced O Single O Separated O Widowed	Childcare: O Mother O Grandparent(s) O Father O Daycare/Nanny O Sibling
Immunizations Up To Date? O Yes O No	