



Nicole Betts, AGNP-C

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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:		Referred By:	
Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> 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.**

<input type="checkbox"/> ADHD	<input type="checkbox"/> Hepatitis/Liver Disease (Specify _____)
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Hiatal Hernia
<input type="checkbox"/> Allergies	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Anemia	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Anxiety	<input type="checkbox"/> HIV
<input type="checkbox"/> Arrhythmia (Irregular Heart Beat)	<input type="checkbox"/> Incontinence (Specify <u>Bowel</u> or <u>Bladder</u> )
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Irritable Bowel Syndrome (IBS)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Benign Prostatic Hypertrophy	<input type="checkbox"/> Learning Disorder (Specify _____)
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Lupus
<input type="checkbox"/> Bleeding/Clotting Disorders	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Cancer (Specify _____)	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Obesity
<input type="checkbox"/> Chronic Pain (Specify _____)	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Osteopenia/Osteoporosis
<input type="checkbox"/> Dementia	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Depression	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Diabetes (Specify <u>Type 1</u> or <u>Type 2</u> )	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> DVT (Blood Clot)	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Edema	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Gastroparesis	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> GERD (Acid Reflux)	<input type="checkbox"/> STD (Specify _____)
<input type="checkbox"/> Glaucoma/Macular Degeneration	<input type="checkbox"/> Stroke
<input type="checkbox"/> Headache (Specify _____)	<input type="checkbox"/> Thyroid Disorder (Specify _____)
<input type="checkbox"/> Heart Attack (MI)	<input type="checkbox"/> Visual Disorder
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> 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:
<input type="radio"/> Cardiac Stress Test	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> Colonoscopy	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> DEXA Scan	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> Echocardiogram	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> EKG	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> Eye Exam	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> Diabetic Foot Exam	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> Influenza Vaccine	<input type="radio"/> Current <input type="radio"/> Unknown	
<input type="radio"/> Mammogram	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> PAP Exam	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> Physical Exam (Annual)	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> Pneumonia Vaccine	<input type="radio"/> Current <input type="radio"/> Unknown	
<input type="radio"/> Pulmonary Function Test	<input type="radio"/> Normal <input type="radio"/> Abnormal	
<input type="radio"/> Tetanus Vaccine	<input type="radio"/> Current <input type="radio"/> Unknown	

**FAMILY HISTORY – Check if any family member(s) have had any of the following conditions.**

<b>Diagnosis:</b>	<b>Mother</b>	<b>Father</b>	<b>Sister</b>	<b>Brother</b>	<b>Other (Specify)</b>
Alcoholism	0	0	0	0	0
Anxiety	0	0	0	0	0
Arrhythmia	0	0	0	0	0
Asthma	0	0	0	0	0
Bipolar Disorder	0	0	0	0	0
Bleeding Disorder	0	0	0	0	0
Cancer (Type: _____)	0	0	0	0	0
Dementia	0	0	0	0	0
Depression	0	0	0	0	0
Diabetes (Type 1 or Type 2)	0	0	0	0	0
Heart Disease/Heart Attack	0	0	0	0	0
High Blood Pressure	0	0	0	0	0
High Cholesterol	0	0	0	0	0
Kidney Disease	0	0	0	0	0
Lupus/Rheumatoid Arthritis	0	0	0	0	0
Obesity	0	0	0	0	0
Osteoarthritis	0	0	0	0	0
Osteoporosis	0	0	0	0	0
Sleep Apnea	0	0	0	0	0
Stroke	0	0	0	0	0
Thyroid Disorder	0	0	0	0	0
Other: _____	0	0	0	0	0
Other: _____	0	0	0	0	0

**SOCIAL HISTORY (ADULT)**

Occupation:		Employer:			
Are you Pregnant? 0 Yes 0 No		Do you have children? 0 Yes 0 No		How Many?	Male(s) Female(s)
Tobacco Use 0 Yes 0 No	0 Daily 0 Weekly 0 Less 0 Former/Quit Year _____		0 Chewing 0 Cigarette 0 Cigar 0 Smokeless/E-Cigarette		
Alcohol Use 0 Yes 0 No	0 Daily 0 Weekly 0 Less 0 Former/Quit Year _____		0 Beer 0 Wine 0 Liquor 0 Other: _____		
Caffeine Use 0 Yes 0 No	0 Daily 0 Weekly 0 Less 0 Former/Quit Year _____		0 Chocolate 0 Soda 0 Tea 0 Tablet 0 Coffee		

**SOCIAL HISTORY (CHILD)**

Primary Residence:	0 Mother	0 Father	0 Both Parents	0 Other:
Secondary Residence:	0 Mother	0 Father		0 Other:
Mothers Occupation:			Fathers Occupation:	
Parent's Relationship: 0 Married 0 Divorced 0 Single 0 Separated 0 Widowed			Childcare: 0 Mother 0 Grandparent(s) 0 Father 0 Daycare/Nanny 0 Sibling	
Immunizations Up To Date? 0 Yes 0 No				

