Bay Health Center
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

Primary Care Physician	Primary Care Physician Phone	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Preferred Method of Communication	Preferred Language	How did you find out about our clinic?

Race (The federal government encourages the collection of this data in health clinics. Please circle one): American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, White, Decline to state	Ethnicity (The federal government encourages the collection of this data in health clinics. Please circle one): Latino, Non-Latino, Decline to state	Religious Affiliation, if applicable:

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 _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

_____

_____

_____

Please rate your current pain level on a scale of 0-10 : _____

Recent Health Data

Please fill in any applicable, most recent health data:

Height _____ Weight _____ Home Blood Pressure Reading _____

Annual Exam _____ Blood tests _____ Tetanus Shot _____ Flu Shot _____

Colonoscopy _____ Bone Density test _____ EKG or other Heart Tests _____

Current Medications

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Current Vitamins/Supplements

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Allergies

Medication Name _____ Reaction _____

Medication Name _____ Reaction _____

Past Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS / HIV
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Ear Problems
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis - A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Menstrual Problems
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prostate Disorder
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Skin Disorder
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Sexually Transmitted Infection

Any other medical problems: _____

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Women Only (list most recent date):

Period _____ Age at 1st period _____ Pap _____ Mammogram _____

Pregnancies _____ # Miscarraiges/Abortions _____ # of Living _____ Age at first childbirth _____

Family History

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

- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Bleeding Disorder
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Joint Disorder
- ☐ Kidney Disease
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Migraines
- ☐ Psychiatric Disorders
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder

Details: _____

_____

_____

_____

Exercise History

times/week _____ types of exercise _____

Lifestyle Factors

Do you have a current sexual partner?

☐ Yes ☐ No # of partners in past year _____

Have your sexual partner(s) been:

☐ Male ☐ Female ☐ Both

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked? If "yes" please answer three extra questions below

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Have you been screened for lung cancer with a CT scan?

☐ Yes ☐ No

Have you been screened for abdominal aneursyms with an ultrasound?

☐ Yes ☐ No

Have you ever used recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

type & # drinks/week _____