



PATIENT REGISTRATION FORM

Today's date:				
PATIENT INFORMATION				
Patient's last name:		First:	Middle:	Birth date: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Mailing address:		City:	State:	ZIP Code:
Parent / Guardian Name if minor:				
Address if different:		City:	State:	ZIP Code:
Person Responsible for Payment:		Relationship to Patient:		
Address, if different:		City:	State:	ZIP Code:
Home Phone:		Mobile:	Work:	
Referring Physician:		Phone No.:	City:	
COMMUNICATION OF YOUR PROTECTED HEALTH INFORMATION				
THE FOLLOWING INFORMATION WILL ASSIST US IN COMMUNICATING WITH YOU ABOUT YOUR CARE WHILE PROTECTING YOUR CONFIDENTIALITY.				
Preferred Method of Contact: Please check box(es) and enter information	<input type="checkbox"/> Email:		<input type="checkbox"/> Home Phone:	
	<input type="checkbox"/> Mobile Phone:		<input type="checkbox"/> Work Phone: ext.	
	<input type="checkbox"/> Mail		<input type="checkbox"/> Other:	
If you are unavailable, may we contact you via:	Email? <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone? <input type="checkbox"/> No <input type="checkbox"/> Yes: Home / Mobile / Work (Please circle all which apply)		
May we speak with someone other than you regarding your care?	Name:	Relationship to Patient:	Phone No.:	
INSURANCE INFORMATION				
Primary Insurance Company Name:				
Contract / ID / Claim No or Soc Sec No.:		Group No.:	Co-payment:	
Subscriber's Full Name:			Birth date: / /	
Subscriber's Address:		City:	State:	ZIP Code:
Patient Relationship to Subscriber:		Subscriber's Employer:		
Secondary Insurance Company Name:				
Contract / ID / Claim No or Soc Sec No.:		Group No.:	Co-payment:	
Subscriber's Full Name:			Birth date: / /	
Subscriber's Address:		City:	State:	ZIP Code:
Patient Relationship to Subscriber:		Subscriber's Employer:		
REGARDING TODAY'S VISIT				
Is this a Work- Related Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this an Auto accident related Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Injury:
Employer's Address:		City:	State:	ZIP Code:
IN CASE OF EMERGENCY				
Name:		Relationship to patient:	Phone:	
I certify that the above information is my personal information and has not been fraudulently derived. I understand that it is MY RESPONSIBILITY to notify MedQuan Sports Medicine of any changes to the above instructions.				
_____ <i>Patient / Guardian signature</i>			_____ <i>Date</i>	



HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (<i>Last, First, M.I.</i>):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Number of Children:	Occupation:	Employer:

PERSONAL HEALTH HISTORY

Allergies: List all of write NONE if none

Name of Allergen	Date of Onset	Reaction You Had

Medications: Include vitamins, herbal supplements and over the counter medications (if list, please write "See Attached")

Drug	Strength	Who Prescribed

Past Personal / Family Medical History- Leave blank if it does not apply

	Relationship to Patient					
	Self	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Asthma						
Anxiety						
Bipolar						
Blood Clots / Blood Disorder						
Breast Cancer						
Colon Cancer						
Diabetes						
Depression						
Drug / Alcohol Addiction						
Eating Disorders						
Fractures						
Heart Disease						
Heart Attack (MI)						
High Blood Pressure						
High Cholesterol						
Irritable Bowel (IBS)						
Kidney / Liver Disease						
Osteoporosis						
Seizures						
Sprains						
Stroke						
Thyroid Disease						
Ulcer						
Vision / Hearing Loss						
Other Cancers (List)						
Other, Please Describe:						

Hospitalizations / Surgeries		
Reason	Year	Hospital Name / Doctor's Name

Immunizations and Dates	
<input type="checkbox"/> Chickenpox	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>
<input type="checkbox"/> Flu Shot / Influenza	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Hepatitis B Series	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Other	

Health Habits						
Exercise:	<input type="checkbox"/> Walk	<input type="checkbox"/> Run	<input type="checkbox"/> Bike	<input type="checkbox"/> Daily	<input type="checkbox"/> 2 – 3 times / week	<input type="checkbox"/> Occasionally
Nutrition:	5 – 6 Servings of Fruits / Vegetables per day				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Water Intake (cups / day)				<input type="checkbox"/> 1 – 5 <input type="checkbox"/> 6 +	<input type="checkbox"/> None
	Calcium Supplement				<input type="checkbox"/> 600 mg <input type="checkbox"/> 1200 mg	<input type="checkbox"/> No
Caffeine Intake	<input type="checkbox"/> Yes: <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Pop / Soda <input type="checkbox"/> Other; Amount / Day					<input type="checkbox"/> None
Tobacco:	<input type="checkbox"/> Yes: Amount / Day			No. of years		<input type="checkbox"/> No
Alcohol:	<input type="checkbox"/> Yes: <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Hard Liquor; Amount / Day					<input type="checkbox"/> No
Recreational Drugs:	<input type="checkbox"/> Yes: What Kind(s)?					<input type="checkbox"/> No
Do you have an Advanced Directive? If you have an Advanced Directive, we do not honor them in our office. However, in the event of an emergency, EMS will be notified and will facilitate transfer to a facility that does.				<input type="checkbox"/> Yes, Please provide a copy		<input type="checkbox"/> No

RELEASE OF MEDICAL INFORMATION CONSENT

MedQuan Sports Medicine may release my medical information to the following persons. If there are no names written in this section, we WILL NOT be able to release any information to anyone other than you.	
Name	Relationship to Patient

**PATIENT POLICIES AND PROCEDURES
& NOTICE OF PRIVACY PRACTICES
(Rev 122009.01)**

I have read and agree to the following:

- Payment and Billing Policy & Procedures
- Missed Appointment Policy
- Disclosure of Information for Reimbursement and Assignment of Benefits
- Notice of Privacy Practices (HIPAA)

I certify that my Health History Questionnaire is accurate (pages 2 and 3 of this document).

I understand it is MY RESPONSIBILITY to notify MedQuan Sports Medicine of any changes to the above instructions.

Patient / Guardian Signature

Date