PATIENT REGISTRATION

DATE_____ DOCTOR_____

PATIENT INFORMATION

NAME LAST	FIRST	M.I.	BIRTH DATE	HOME PHONE ( )
ADDRESS			MALE ☐ SINGLE ☐ FEMALE ☐ MARRIED ☐	DIVORCED ☐ WIDOWED ☐
CITY	ZIP CODE		CELL PHONE	SOCIAL SECURITY NUMBER
EMPLOYER			OCCUPATION	WORK PHONE ( )
ADDRESS			CITY	STATE / ZIP CODE
REFERRING DOCTOR	ADDRESS		CITY	STATE / ZIP CODE
IN CASE OF EMERGENCY CONTACT:	NAME			PHONE ( )
ADDRESS	CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT
RESPONSIBLE PARTY			BIRTH DATE	PHONE ( )
ADDRESS	CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT
EMPLOYER			OCCUPATION	WORK PHONE ( )
ADDRESS			CITY	STATE / ZIP CODE

INSURANCE INFORMATION

TYPE OF INSURANCE	I.D. NUMBER	GROUP NUMBER	NAME OF INSURED

CONSENT TO TREATMENT: I authorize and direct Brian S. Sayers, M.D. and/or Stephanie A. Booth, M.D. to perform upon me injections, draw blood and/or any other procedure/treatment they may determine advisable for my well being in their office. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

ASSIGNMENT AND RELEASE: I authorize release of any medical information necessary to process an insurance claim. I agree to be responsible for any copayments and/or services not covered by my insurance. I authorize payment of medical benefits to the physician or supplier of services.

NO SHOW POLICY: No shows and same day cancellations are subject to a $50 charge.

SIGNATURE:_____ Date: _____

Name:_____ Date: _____
Doctor: _____

New Patient Information

Describe your current problem:

List the medications that you take (include over the counter medicines):

List the medicines you are allergic to:

Past Medical History

List all previous surgical procedures and hospitalizations:

Procedure/Diagnosis	Year
_____	____
_____	____
_____	____
_____	____
_____	____
Last Complete Physical Exam _____	____

Symptoms and medical conditions (please check positives):

____Asthma
____High Blood Pressure
____Diabetes
____Heart condition
____Thyroid Problem
____Ulcer
____Gastritis
____Seizure
____Stroke
____Mood Disturbance
____Colitis
____ Kidney Stones
____ Cancer

____Weight Change
____Rash/Skin Condition
____Frequent Headaches
____Dry Mouth or Eyes
____Heartburn/Acid Reflux
____Diarrhea or Constipation
____Visual Disturbance
____Depression or Anxiety
____Sleep Disturbance
____Persistent Fatigue
____Morning Stiffness
____Unexplained Fevers

____ Ulcer or Sores in your Mouth
____ Hands Turn Red, Blue or White With Cold Exposure
____ Rash with Sun Exposure
____ Cough or Other Lung Symptoms
____ Pronounced Hair Loss

Date: _____

Name: _____ Doctor: _____

Family History

Family Member	Alive	Deceased	Cause of Death/Medical Condition
Mother	____	____	_____
Father	____	____	_____
Sister/Brother	____	____	_____
Sister/Brother	____	____	_____
Sister/Brother	____	____	_____
Your Child	____	____	_____
Your Child	____	____	_____
Your Child	____	____	_____

Do you have any family members with arthritis or a rheumatic disease (Lupus, Rheumatoid Arthritis, etc.):

Social History

Describe your work or principle daily activities:

What are your exercise habits?

Are there things in your daily routine that aggravate your condition?

Do you smoke?

Do you drink alcohol? If so, estimate average weekly intake:

Is stress a major problem in your life?