Registration Form

Date ______________________ Home Phone ______________________

Name ______________________ Patient No. ______________________

Address ______________________

______________________ Mobile ______________________

Sex ☐ Male ☐ Female Age ______________________ Date of Birth ______________________

☐ Married ☐ Widowed ☐ Single ☐ Seperated ☐ Divorced ☐ Partnered for __________ yrs

Patient Employer ______________________ Occupation ______________________

Employer/School Address ______________________

______________________ Employer/School Phone ______________________

GP ______________________

Next of Kin ______________________ Phone ______________________

Primary Insurance

Person Responsible for Account ______________________
Last Name First Name Middle Initial

Relation to Patient Date of Birth ______________________

Address (if different than patient's) ______________________

______________________ Phone ______________________

Person Responsible Employed By ______________________ Occupation ______________________

Business Address ______________________

______________________ Business Phone ______________________

Insurance Company ______________________

Contract ______________________ Group ______________________ Subcriber ______________________

Names of other dependents covered under this plan ______________________

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ (and) assign directly to Mr Mosahebi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorise the use of my signature on all insurance submissions.

Mr Mosahebi may use my health care information and may disclose such infomation to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________ ______________________
Signature of Patient, Parent, Guardian or Personal Representative Date

______________________ ______________________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Confidential Health History

Patient Name ______________________ Today's Date ______________

Age ________ Date of Birth ______________ Dat of last physical Examination ______________

What is the resaon for your visit? ______________________________

Sypmtons

Tick box ☑ for symptons you currently have or have had in the past year

Conditions

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

- ☐ Pain, Weakness, Numbness in:
- ☐ Hands or Arms
- ☐ Shoulders or Neck
- ☐ Feet or Legs
- ☐ Back

Genitourinary

- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder control
- ☐ Painful Urination

Gastrointestinal

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Eye/Ear/Nose/Throat

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

Skin

- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Men Only

- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

Women Only

- ☐ Abnomal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flushes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge

Date of last Period

____

Date of last Pap Smear

____

Have you had a manogram? __________

Pregnant? __________

Number of children

____

Conditions

☐ AIDS	☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problem
☐ Alcoholism	☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anorexia	☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Typhoid Fever
☐ Bulimia	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal Infections
☐ Cataracts	☐ Herpes	☐ Polio	☐ Venereal Disease

Medications - List all medications you are currently taking

____

____

____

____

Allergies

____

____

____

____

Pharmacy Name ______________________________ Phone ______________________________

Hospitalisations

Year	Reason for Hospitalisation and Outcome
________	______________________________
________	______________________________
________	______________________________
________	______________________________

Health Habits

☑ How Much

☐ Caffeine ______________________________

☐ Tobacco ______________________________

☐ Recreational Drugs ______________________________

____

Occupational

Does your work expose you to: ☐ Stress ☐ Heavy Lifting ☐ Hazardous Substance ☐ Other

______________________________ ______________________________

Signature of Patient, Parent, Guardian or Personal Representative Date