New Patient Registration

Patient Information

Name ____ Soc. Sec. # ________________
Last Name First Name Initial

Address ____
Street City State Zip

Phone # Home: ________________ Work: ________________ Cellular: ________________

Email____

Sex __ M __ F Age ___ Birth date _________ Single__ Married__ Widowed__ Divorced__ Separated__

Employer __________________________________ Occupation__________________________

In case of emergency who should we notify _______________________? Phone ______________

How did you find out about our office? ____

Primary Insurance

Name of Insured ____
Last Name First Name Initial

Relation to Patient ______________________ Birth date __________ Soc. Sec. # ________________

Address (if different form Patient) ____
Street City State Zip

Insured Employed by __________________________________ Occupation ________________

Bus. Address ____ Bus. Phone ________________

Insurance Co ____
Name Address Phone #

Member No ________________ Group # ________________ Subscriber # ________________

Additional Insurance

Is Patient covered by additional insurance? ___Yes ___No

Name of Insured ____
Last Name First Name Initial

Relation to Patient ______________________ Birth date __________ Soc. Sec. # ________________

Address (if different from Patient) ____
Street City State Zip

Insured Employed by __________________________________ Occupation ________________

Bus. Address ____ Bus. Phone ________________

Insurance Co ____
Name Address Phone #

Member No ________________ Group # ________________ Subscriber # ________________

Assignment and Release

I, ______________________, certify that I (or my dependent) have insurance coverage with __________________ and assign directly to **Mountain Streams Medical Center, PC** all insurance benefits for services received there. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ ______________
Signature of Responsible Party Date

Patient Name____________________________________

Family Physician

Family Physician ____________________ Phone #____________________

Address ____________________ Fax # ____________________

Current Medications

Current Medications, Vitamins and Supplements, or Asprin products

1. ____________________ 5. ____________________
2. ____________________ 6. ____________________
3. ____________________ 7. ____________________
4. ____________________ 8. ____________________

Please list any known allergies to medications ____________________

Health History

Please list any Past Illnesses ____________________

Please list any Current Illness____________________

Please list any Past Surgeries ____________________

Circle any of the following that applies to you:

Headaches	Breast Lump	Breathing Problems	Hemorrhoids	Family Problems
Eye Problems	High Blood Pressure	High Cholesterol	Phlebitis	Sexual Problem
Hearing Problems	Arthritis	Heart Trouble	Serious Injury	Sleeping Difficulty
Dental/Gum Disease	Gout	Liver Disease	Tuberculosis	Depression
Thyroid Disease	Fainting/Convulsions	Stomach Trouble	Rheumatic Fever	Nervousness
Diabetes	Abnormal Bleeding	Kidney Disease	Venereal Disease	Stroke
Anemia	Hives or Rash	Trouble Urinating	Alcohol /Drug Problems	Other ______________
Cancer	Hepatitis	Bowel Trouble	Weight Loss	

List Childhood Diseases____________________

Hospitalizations: ____________________

Other Health Issues:

Tobacco use: ______________ Age started__________ Amount__________

Alcohol: __________________ How many Drinks per week________________________

Pregnant? YES NO Maybe (Circle One)

Family Health History

Family History	Alive/Deceased	Age	Family Health Problems- (cause of death)	Do you have any close relatives with
Father				High Cholesterol
Mother				Heart Trouble
Spouse				Cancer (Breast, Prostate, Colon)
Brothers/Sisters				Diabetes
				High Blood Pressure
				Mental Illness
				Thyroid Disease
Children				Bleeding Trouble or Blood Clots
				Hemorrhoids
				Alcohol / Drug Problems
				Alzheimer's

Patient Name____________________

History

Bright red rectal bleeding is a common symptom of hemorrhoids. However, other serious colon and rectal disorders can cause blood in the stool. Please take the time to answer the following questions.

Have you ever seen a physician for rectal bleeding? ___Yes ___No if Yes, When? _______ (Yrs) ________ (age)

Have you ever had any of the following diagnostic studies?

Sigmoidoscopy?	___ Yes ___ No	If Yes, When _______ (Yrs) ________ (age)
Barium enema?	___ Yes ___ No	If Yes, When _______ (Yrs) ________ (age)
Colonoscopy?	___ Yes ___ No	If Yes, When _______ (Yrs) ________ (age)

Have you ever been advised by a physician to have any of the above tests? ___ Yes ___ No

Have you or anyone in your family ever been diagnosed with colon cancer? ___ Yes ___ No

Have you ever been diagnosed with Crohn's disease, ulcerative colitis, diverticulitis, or and ulcer?

Have you had any of the following Symptoms?

A change in bowel habits?	___ Yes ___No
A change in the way bowel movements look?	___ Yes ___No
Blood mixed in bowel movements?	___ Yes ___No

Hemorrhoid History

Pain associated with hemorrhoids? ___ Yes ___ No

____ Pain upon standing	____ Pain upon sitting	____ Pain upon bending
____ Pain upon stooping	____ Pain upon lifting	____ Pain with other

Bleeding associated with hemorrhoids? ___ Yes ___ No Frequency ____ Constant _____ Intermittent

Itching associated with hemorrhoids? ___ Yes ___ No Frequency ____ Constant _____ Intermittent

Protrusion of tissue? ___ Yes ___ No

Please note any additional symptoms: ____

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Please list all therapies, remedies and treatments (doctor prescribed or over-the-counter) you have tried. Please be as detailed as possible:

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Patient Name____