

PATIENT REGISTRATION

Chart # _____ Doctor _____ Date _____

THIS SECTION REFERS TO THE PATIENT ONLY. PLEASE PRINT.								
Patient's Last Name		First	Initial	Preferred Name				
Address		Apt#	Home Phone #	Age	Birthdate / /			
City		State	Zip	Cell Phone #	SS#			
Patient's Employer			Work Phone #	MARITAL STATUS				
				S	M	W	D	O
Employer's Address			Occupation (Indicate if Student, Retired, Stay at home parent etc.)					
City		State	Zip					
Referring Doctor		Phone Number	Primary Care Physician		Phone Number			
Referral Source <input type="checkbox"/> Doctor <input type="checkbox"/> Family/Friends <input type="checkbox"/> Hospital <input type="checkbox"/> Insurance Company <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages								

SPOUSE/PARTNER OR GUARDIAN					
Last Name		First	Initial	Relationship to Patient	
Address		Apt#	Home Phone #	Age	Birthdate / /
City		State	Zip	Cell Phone #	SS#
Employer			Work Phone #		
Employer's Address			Occupation (Indicate if Student, Retired, Stay at home parent etc.)		
City		State	Zip		

EMERGENCY CONTACT (Other than listed above)		
Name	Phone Number	Relationship to Patient

Primary Insurance Name		Address			Phone Number	
Insured ID Number	Subscriber Name	Relationship to Subscriber			Group Number	
		Self	Spouse	Child		
Secondary Insurance Name		Address			Phone Number	
Insured ID Number	Subscriber Name	Relationship to Subscriber			Group Number	
		Self	Spouse	Child		

I hereby authorize Portland Ob/Gyn Associates, PC, to release all information necessary regarding services rendered and permit payment directly to Portland Ob/Gyn Associates, PC, for any benefits due me related to those services. I understand that I am responsible for all charges regardless of insurance. I also understand that if my insurance is through an HMO or PPO plan, it is my responsibility to verify that my provider is a member of that plan, obtain a referral from my primary care provider if one is necessary, and pay any co-payments at the time of each visit. I further understand that if the nature of the service is such that it is not covered by my policy I will be responsible for payment of the entire bill. I am aware that there will be an additional \$50 charge if it becomes necessary to forward my account to an outside collection agency.

Signed _____ Dated _____

EMR Health History Questionnaire

Patient Name: _____

Birthdate: _____

Preferred Name: _____

Previous Hospitalizations, Surgery, Serious Injury

Type	Year
_____	_____
_____	_____
_____	_____

Current Medications:

Name	Dose	Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug Allergies: Yes / No

Name	Reaction	Name	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name of Preferred Pharmacy you use, address & phone number:

Do you prefer to have a medical assistant present when the doctor examines you?

Yes / No

Past or Present Illness

Comments:

Diabetes:	Yes	No	_____
Thyroid:	Yes	No	_____
High Blood Pressure:	Yes	No	_____
Heart Disease:	Yes	No	_____
Headaches:	Yes	No	_____
Stroke:	Yes	No	_____
Respiratory/Asthma	Yes	No	_____
Stomach or Bowel Problems:	Yes	No	_____
Blood Transfusions:	Yes	No	_____
Blood Disorder:	Yes	No	_____
Bladder Infection:	Yes	No	_____
Uncontrolled Loss of Urine:	Yes	No	_____
Mental Health:	Yes	No	_____
Hyperlipidemia:	Yes	No	_____
Osteopenia/Osteoporosis:	Yes	No	_____
Arthritis:	Yes	No	_____
Cancer:	Yes	No	_____
Endometriosis:	Yes	No	_____
Fibroids:	Yes	No	_____
Sexual Abuse:	Yes	No	_____
Other:	Yes	No	_____

