New Patient Registration Form

PATIENT INFORMATION

NAME: (Last) ____________________________ (First) ________________________ (Middle) __________

(Nickname (if applicable)): _________________________________

Gender: (M/F) ____________ Date of Birth: _________________________ SSN: _____________________

Race/Ethnicity (check all that apply): ☐ White ☐ Black/African American ☐ Hispanic ☐ Asian

☐American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Pacific Islander ☐ Other

ADDRESS: ____

City: __________________________________ State: _______________ Zip: ________________

GUARDIAN/MOTHER NAME: ____

GUARDIAN/FATHER NAME: ____

HOME PHONE #: ____________________ CELL #:________________________ WORK #: ______________

EMAIL ADDRESS: ____

EMERGENCY CONTACT: ________________________________ PHONE #: __________________________

RELATIONSHIP TO EMERGENCY CONTACT: ____

REFERRING PHYSICIAN: ____________________ PHONE #: __________________ FAX #: _____________

PRIMARY CARE PHYSICIAN: ____________________ PHONE #: ________________ FAX #: ____________

PHARMACY INFORMATION

LOCAL PHARMACY: ___________________________ PHONE #: ___________________

PHARMACY ADDRESS: ____

MAIL ORDER PHARMACY: ______________________ PHONE #: _________________ FAX #: ___________

PATIENT HISTORY: Please provide as much information as possible to help us get to know you or your child better.

REASON FOR VISIT:

____

____

PRIOR DIAGNOSTIC TESTING: (Please provide approximate dates of when study was done and results if known. (When possible, please provide results of below studies or CDs with images)

MRI/CT head: EEG:

Genetic testing: Others:

EDUCATION STATUS: ___________________________ **OCCUPATION** (if applicable): ________________

II. Medications Please list medications the patient is currently taking, include dose and frequency taken (if known):

1. ____ 5.____

2. ____ 6.____

3. ____ 7.____

4. ____ 8.____

Please list medications the patient has taken in the past:
____

*Drug Allergies: ____

III. Medical History:

Has the patient been hospitalized in the past? Yes/No

Date:________________________Reason for hospitalization:_______________________________

Has the patient had surgery in the past? Yes/No

Date:__________________ Reason for surgery:____

Are the patient's immunizations up to date? Yes/No

Birth History:

Was the patient born full term or premature? ___________weeks

Birth weight: ___________

Delivery: check one vaginal____ c-section____

Complications or difficulties? _______________________________

IV. Development:

sat up ________ crawled ________ walked __________ fed him/herself ___________ first word __________ spoke in sentences ____________ speech concerns? yes/no

Were developmental skills ever lost? Please explain:

____

____

Any concerns regarding sleep? Yes/No

____

V. Family History: Please list any known diseases/disorders in family.

Mother: ____

Father: ____

Mother's parents: ____

Father's parents: ____

Siblings: ____

Aunts/Uncles: ____

VI. Social History:

Who does the patient live with? ____

Mother's age: ___________ Occupation: ____

Father's age: ___________ Occupation: ____

Names and ages of siblings:

____

____

Name of school patient attends: ___________________________________ Grade: ____________

Concerns regarding school performance: ____

VII. Review of Systems: Is the patient currently reporting any of the following symptoms? (circle all that apply)

NEUROLOGICAL	Headaches	Seizures	Weakness	Numbness
GENERAL	Fatigue	Fever	Recent illness	Dizziness
EYES	Vision changes	Blurry vision	Vision loss	Eye pain
HEAD/EARS/THROAT	Congestion	Sore throat	Ringing in ears	Hearing loss
CARDIOVASCULAR	Chest pain	Palpitations	Syncope	Exercise intolerance
RESPIRATORY	Difficulty breathing	Wheezing	Cough	Snoring
GASTROINTESTINAL	Abdominal pain	Nausea	Vomiting	Constipation
SKIN	Rash	Moles/birthmarks	Skin Lesions	Nail changes
MUSCULOSKELETAL	Joint Pain	Joint Swelling	Back pain	Muscle pain
ENDOCRINE	Weight gain	Weight loss	Hair loss	Temperature intolerance
HEMATOLOGICAL	Easy bruising	Nose bleeds	Bleeding disorder	Anemia
PSYCHIATRIC	Depression	Sadness	Hallucinations	Anxiety

OTHER CONCERNS TODAY: ____

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