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New Patient Registration Form

(please print)

Demographics

Name (first, last): _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Sex: ❑Male ❑Female

Mailing Address: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____-_____

Home Phone: _____ Work Phone: _____ ext._____

Cell Phone: _____ Other: _____

Preferred Contact Number: ❑Home ❑Cell ❑Work ❑Other

Emergency Contact: _____ Relationship: _____

Phone: _____ ❑Home ❑Cell ❑Work

Referred to our office by: ❑Physician_____ ❑Hospital/Facility _____

❑Patient/Family/Friend ❑Attorney_____ ❑Other: _____

Primary Care Physician: _____

Referring Physician: _____

Pharmacy Name & Address: _____

Pharmacy Phone Number: _____

Race:

❑White ❑American Indian/Alaska Native ❑Asian ❑Other

❑Black/African American ❑Native Hawaiian/Other Pacific Islander ❑Patient Declined/Unknown

Ethnicity: ❑Spanish/Hispanic ❑Not of Hispanic Origin

Primary Language: _____ Country: _____

Name (first, last): _____ Date: _____/_____/_____

Medical Insurance Information (***provide card and/or referral***)

Primary Insurance Company: _____

ID #: _____ Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other

Policy Holder's Name: _____ DOB: _____/_____/_____

Policy Holder's Employer: _____

Secondary Coverage (*if applicable)*:

Insurance Company Name: _____ ID #: _____

Policy Holder's Name: _____ DOB: _____/_____/_____

❑**Yes** ❑**No** today's visit, is a **motor vehicle accident** related injury.

- If **Yes**, please complete **NYS No-Fault Verification of Treatment Form ("NF-3")**.
- If **No**, proceed to **Medical History** section.

❑**Yes** ❑**No** today's visit, is a **work-related** injury.

- If **Yes**, please complete **Workers' Compensation** section.
- If **No**, proceed to **Medical History** section.

Name (first, last): _____ Date: _____/_____/_____

Medical History

1. Past Medical History: Do you now or have you ever had?

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (*please list*):

_____

_____

2. List all surgeries' dates with reasons and any hospital admissions related to today's visit:

_____

_____

3. List all prescription medications with dose (*include strength & number of pills per day*) and frequency (*how often you take them*) (***i.e. Advil 200 mg,1 tablet by mouth 2x a day***)

4. Medication/Drug/Food allergies ***(please include: IV Dye, CT Contrast, shellfish, etc.)***: ❑No ❑Yes, to what?:

_____

_____

Name (first, last): _____ Date: _____/_____/_____

5. Family History: list all medical problems in your immediate family (*i.e. diabetes, arthritis, cancer, etc.*):

_____

_____

_____

6. Currently Working? ❑Yes ❑No

a. If Yes: ❑Light Duty ❑Full Duty

i. What is your occupation? _____

b. If Retired, what was your prior occupation? _____

7. Do you smoke cigarettes? ❑Yes ❑No

c. If yes, how many cigarettes or packs per day? _____

8. Have you stopped smoking? ❑Yes ❑No

d. If so, when? _____

9. Do you drink alcohol? ❑Yes ❑No

e. If yes, how many drinks per day? _____

10. Other drug use? ❑Yes ❑No

f. If yes, what drug and how much? _____

Symptoms Checklist

Symptoms	**Please Circle**	
Fever or night sweats	Yes	No
Chest pain	Yes	No
Shortness of breath	Yes	No
Loss of bowel control	Yes	No
Loss of bladder control	Yes	No
Inflammatory arthritis	Yes	No
Skin rashes	Yes	No
Weakness	Yes	No
Depressed mood	Yes	No
Difficulty sleeping	Yes	No
Diabetes or thyroid disease	Yes	No

Name (first, last): _____ Date: _____/_____/_____

Pain Diagram

1. Where is your pain? Where is your numbness/tingling?

   Please mark on the diagrams:

   Pain = **X**
   Numbness/tingling = **O**
   Both = ⊗

2. Was there an injury? If yes, what was the date of injury?

3. How long have you had your pain?

4. Please describe the quality of your pain.
   (*sharp, dull, stabbing, ache, throb or other*)

5. Please rate your current pain level from 0 to 10.

6. Does your pain radiate or travel?

7. Is your pain constant or does it come and go?

8. What makes the pain worse? (*bending, lifting, sitting, standing, walking or other*)

9. What makes the pain better? (*medications, rest, therapy, ice, heat, or other*)

10. Do you have any numbness or tingling?