HOLLEY-NAVARRE MEDICAL CLINIC

NEW PATIENT /UPDATED MEDICAL HISTORY

PLEASE COMPLETE IN BLACK INK ONLY

Completed by (signature) _____ on (date) _____/_____/_____

Name: _____ Date of Birth _____

SSN: _____-_____-_____ Phone: _____-_____-_____ Age: _____ Gender: M F

Last Physician: _____ Date of Last Physical: _____/_____/_____

List diseases or conditions that run in your biological family: _____

_____

List diseases or conditions that you have or have had: _____

_____

CURRENT MEDICATIONS AND DOSAGES:

MEDICATION	DOSAGE	WHEN DO YOU TAKE IT	WHY DO YOU TAKE IT

DRUG ALLERIES: _____

PREFERRED PHARMACY: _____

PAST SURGERIES:

Answer YES/NO, if yes, indicate year of surgery
Gallbladder Y N _____
Hysterectomy Y N _____
Appendectomy Y N _____
Tonsillectomy Y N _____
Other (specify) _____
_____
_____
_____

SOCIAL HISTORY:

Do you smoke? Y N
if yes, how much? _____ packs per day
if no, did you ever smoke? Y N
Quit date _____/_____/_____
Drink alcohol? Y N
If yes, how much and how often _____
_____

Patient Registration Form

PATIENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

SSN: _____-_____-_____ Date of Birth _____/_____/_____ Marital Status: _____ Race: _____

Sex: _____ Phone Number: _____-_____-_____ Home Address: _____

City: _____ State: _____ Zip: _____

Student FT/PT: _____ Employer: _____

Employer Address: _____ Employer Phone Number _____-_____-_____

PERSON RESPONSIBLE FOR BILL

Name: _____ Relationship to patient: _____

SSN: _____-_____-_____ Date of Birth _____/_____/_____ Sex: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____-_____-_____ Work Number: _____-_____-_____

Employer: _____

Employer Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to patient: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____-_____-_____ Work Number: _____-_____-_____

Employer: _____

Employer Address: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Insurance Co. Address: _____

Policy # _____ Group # _____Group Name: _____

Subscriber Name: _____ Relationship to Patient: _____

SSN: _____-_____-_____ Date of Birth _____/_____/_____ Sex: _____

Subscribers Address: _____

Secondary Insurance Company: _____

Insurance Co. Address: _____

Policy # _____ Group # _____Group Name: _____

Subscriber Name: _____ Relationship to Patient: _____

SSN: _____-_____-_____ Date of Birth _____/_____/_____ Sex: _____

Subscribers Address: _____

ACKNOWLEDGMENT OF RECEIPT

Notice of Patient Privacy Practices

By singing this Written Acknowledgment of Receipt Notice of Patient Privacy Practices ("Acknowledgment"), I hereby expressly acknowledge my receipt of Notice of Patient Privacy Practices.

Patient, or Legal Representative, Signature

Printed Patient, or Legal Representative, Name (or Label)

_____

Date