MULTICARE PHYSICIANS Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
DO YOU HAVE A LIVING WILL OR MEDICAL ADVANCE DIRECTIVE? ( ) YES ( ) NO		E-MAIL ADDRESS	
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

ETHNICITY: ( ) Hispanic ( ) Non-Hispanic	RACE : ( ) AMERICAN INDIAN OR ALASKAN NATIVE ( ) ASIAN ( ) BLACK OR AFRICAN AMERICAN ( ) HISPANIC ( )WHITE ( ) OTHER _____	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

CONSENT TO TREAT AND ASSIGNMENT OF BENEFITS : I authorize Multicare Physicians to perform procedures and treatment including administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary, including the release of of HIV/AIDS, Mental Health, Substance Abuse and any reportable communicable diseases. I hereby authorize my insurance benefits be paid directly to the Multicare Physicians and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

FINANCIAL AGREEMENT

I understand that in the patient receiving services from Multicare Physicians, I agree:

- I am responsible for all expenses for treating the patient.
- Payment of applicable charges, co-pay, co-insurance and deductible are due at the time of the appointment
- I am responsible for non-covered insurance benefits, co-insurance, co-pays and deductibles.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

MULTICARE PHYSICIANS Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

*** **Preferred Pharmacy:**

Allergies

❑ NONE/No Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Contrast Dye ❑ Latex ❑ Morphine ❑ Penicillin
❑ Wheat
❑ Sulfa Drugs

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

❑ ADOPTED	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Occupation: _____ ☐ Retired ☐ Disabled (reason _____)
☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed
❑ allergies
❑ anemia
❑ arthritis conditions
❑ asthma
❑ arterial fibrillation
❑ bleeding problems
❑ BPH
❑ CAD coronary artery disease
❑ cancer
❑ cardiac arrest
❑ celiac disease
❑ chest pain
❑ CHF congestive heart failure
❑ chronic fatigue syndrome
❑ depression
❑ diabetes
❑ drug/alcohol abuse
❑ erectile dysfunction
❑ fibromyalgia
❑ Gerd
❑ heart disease
❑ high cholesterol
❑ hyperinsulinemia
❑ hyperlipidemia
❑ hypertension
❑ hypogonadism male
❑ hypothyroidism
❑ infection problems
❑ insomnia
❑ irritable bowel syndrome
❑ kidney problems
❑ menopause
❑ migraines/headaches
❑ neuropathy
❑ onychomycosis
❑ organ injury
❑ osteoporosis
❑ pulmonary embolism/blood clot in legs
❑ seizure disorders
❑ shortness of breath
❑ sinus conditions
❑ stroke
❑ syndrome X
❑ tremors
❑ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

❑ **I DO NOT TAKE ANY MEDICATION**

MEDICATION	DOSAGE	PERSCRIBING DOCTOR