Eastside Medical Group
Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr./Sr.

Patient's Name (Last) _____ (First) _____ (MI) ____ Previous Name _____

Address _____

City, State _____ ZIP_____

Home Phone _____ Cell No. _____ Work Phone _____Ext. _____

E-Mail Address:_____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Social Security Number ___-___-____

Race/Ethnicity ☐Asian ☐ Black or African American ☐ Caucasian ☐ Hispanic or Latino
☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Declined

Language ☐ English ☐ Spanish ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Primary Care Provider (PCP) _____ Referring Provider _____

Pharmacy _____ Pharmacy Phone_____

Employer Name _____Employer Phone _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Relationship to Patient _____

Do you have a living will? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

☐ Self

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Date of Birth MM ____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____

(If different from patient) Address _____City, State _____ ZIP ____

Employer _____ Employer Phone Number_____

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Primary Insurance _____Insured _____DOB_____

Secondary Insurance _____Insured _____DOB_____

How did you hear about us?

☐ Website ☐ Internet Search ☐ Internet Advertisement ☐ Family/Friends ☐ Facebook ☐ Magazine/Newspaper Ad

☐ Another healthcare provider: _____ ☐ Physician Directory ☐ Hospital MD Referral – Medline

EASTSIDE SURGICAL ASSOCIATES DATE:_____

Name: _____ Date of Birth: _____ Age: _____

Male / Female (circle one) Pregnant Yes / No (circle one)

Primary care Doctor _____ Referring Doctor _____

Other Doctors _____

Reason you are here: _____

SOCIAL HISTORY:

Marital Status: ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Widow/Widower
Children _____ Occupation/Job _____

HABITS

Smoking: ❑ Never smoked ❑ Former smoker ❑ Current smoker / How Long? _____ Packs per day?_____
Do you dip or chew tobacco? ❑ Yes ❑ No If yes, how much per day? _____
Do you drink alcoholic beverages? ❑ Yes ❑ No Drinks per occasion? _____ Drinks per week? _____
Do you drink beverages that contain caffeine: (coffee, tea, soda) _____ cups per day
Do you use recreational drugs? If yes, what and how often? _____

CURRENT MEDICATIONS:

Include herbal and over-the-counter drugs. List and name dose. Using additional sheet if needed.

1. _____ 5._____
2._____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

MEDICATION ALLERGIES: ❑ **No medication allergies** Are you allergic to latex? ❑ Yes ❑ No

Name & type of reaction: _____

_____

_____

PAST MEDICAL HISTORY:

Please check below if you have, or have had, any of the following medical conditions: ❑ **No past medical problems**

❑ Acid reflux
❑ Adverse reaction to anesthesia
❑ Alzheimer's or significant memory loss
❑ Anemia
❑ Angina or chest pain
❑ Arthritis
❑ Asthma
❑ Atrial fibrillation or erratic heartbeat
❑ Bleeding problems
❑ Blood transfusion
❑ Blood clot in leg(s) or lung(s)
❑ Bruise easily
❑ Cancer
Type: _____
❑ Congestive heart failure
❑ Dental disease
❑ Depression
❑ Diabetes
❑ Emphysema
❑ Epilepsy/Seizures
❑ Fibromyalgia
❑ Gallbladder disease
❑ Gout
❑ Heart disease
❑ Hemophilia / Excessive bleeding
❑ Hepatitis
❑ High blood pressure / Hypertension
❑ High cholesterol
❑ HIV or AIDS
❑ Infections: _____
❑ Kidney/Bladder disease
❑ Leg pain
❑ Lung disease
❑ Lupus
❑ Osteoporosis
❑ Peripheral vascular disease
❑ Pneumonia
❑ Psychiatric disorder
❑ Rheumatoid arthritis
❑ Sickle cell
❑ Sleep apnea / CPAP machine
❑ Stroke (CVA)
❑ Thyroid Disease
❑ Tuberculosis
❑ Other not listed, explain:

Name _____DOB _____

SURGICAL HISTORY:

Please check below if you have had any of these surgeries: ❑ **No previous surgery**

❑ Aneurysm - Abdominal
❑ Angioplasty/stents
❑ Appendectomy
❑ Artery bypass of arm or leg
❑ Breast surgery
❑ Caesarean section
❑ Carotid surgery
❑ Cataract surgery
❑ Colon Surgery
❑ Fistula - Which Arm _____
❑ Gall Bladder
❑ Gastric bypass surgery
❑ Heart Stents
❑ Hernia surgery
Where: _____
❑ Hysterectomy
❑ Nasal Surgery
❑ Open Heart surgery
❑ Pacemaker/Defibrillator
❑ Prostate surgery
❑ Spine surgery
❑ Tonsils
❑ Total Hip
❑ Total Knee
❑ Other not listed, explain _____
_____

FAMILY HISTORY:

Please check below if Mother, Father, Siblings have had any of the following: ❑ **No family medical history to report**

	Who		Who		Who
❑ Adverse reaction to anesthesia	_____	❑ Coronary artery disease	_____	❑ Hypertension	_____
❑ Bleeding disorders	_____	❑ Depression	_____	❑ Osteoporosis	_____
❑ Blood clots/Pulmonary embolism	_____	❑ Diabetes	_____	❑ Rheumatoid arthritis	_____
❑ Cancer Type: _____	_____	❑ Heart disease	_____	❑ Stroke	_____

REVIEW OF SYSTEMS:

Please check below if you have any of these medical conditions TODAY or recurring: ❑ **No review of symptoms to report**

Review of systems: check in box=normal Circle positive responses

		OTHER/REMARKS
{ } CONST	fever, chills, fatigue, recent weight gain/loss, appetite problems, night sweats	_____
{ } EYES	double vision, blurring, difficulty seeing, pain	_____
{ } ENT	deafness, sinusitis, hoarseness, dizziness, nose bleeds, ear pain, sore throat	_____
{ } HEART	chest pain, palpitations, murmur, extra beats, arm/jaw pain	_____
{ } LUNG	shortness of breath, wheezing, cough, bloody sputum, asthma	_____
{ } INTESTINAL	constipation, diarrhea, rectal bleeding, nausea, vomiting, heartburn, abdominal pain	_____
{ } URINARY	pain with urination, frequency, blood in urine, hesitancy, incontinence, stones	_____
{ } BREAST	breast masses, pain, discharge, cancer	_____
{ } GYN	Irregular periods, hysterectomy, partial/complete	_____
{ } NEURO	seizures, loss of balance/coordination, weakness, memory loss, slurred speech	_____
{ } ENDOCRINE	excessive thirst, excessive urination, heat/cold tolerance	_____
{ } SKIN	persistent rashes or lesions, changes in moles, bleeding, itching	_____
{ } MUSCULOSKELETAL	stiffness, joint pain/deformity, muscle wasting, spine pain radiating to arms/legs	_____
{ } BLOOD/LYMPHATIC	anemia, bleeding tendencies, swollen lymph nodes	_____
{ } PSYCH	depression, anxiety, hallucinations, sleep disturbances	_____
{ } ALLERGIC AND IMMUNOLOGIC	hives, eczema, persistent itching	_____

Other problems not covered above:

To Be Filed Out By Nurse

HEIGHT: _____ WEIGHT: _____ TEMP: _____ PULSE: _____ O2 SAT: _____

BP RIGHT ARM: _____ BP LEFT ARM: _____

FLU SHOT: ❑ Yes ❑ No Month _____ PNEUMONIA VACCINE: ❑ Yes ❑ No