Patient Name: _____Date of Birth: _____

What are we seeing you for today? _____

Are you allergic to any medications? If yes which ones and what side affects did you experience?
_____

Who is you Primary Care Physician? _____

Address: _____Phone Number: _____

What Pharmacy do you use? _____Location:_____

Phone Number: _____

How did you hear about the office? _____

Social History:

Occupation: _____

Highest level of Education: _____

Marital Status: Single Married Divorced Widow

Live alone or with others: _____

Number of children: _____

Alcohol Pre-Pregnancy: None Occasional Moderate Heavy

Alcohol intake: None Occasional Moderate Heavy

Alcohol Years of use: _____

Smoking Pre-Pregnancy: YES/NO

Smoking-how much? _____

Tobacco-years of use: _____

Illicit drugs pre-pregnancy: YES/NO

Illicit drugs: _____

Illicit drugs years of use: _____

Is blood transfusion acceptable in an emergency? YES/NO

Is anesthesia consult planned? YES/NO

Advance directive: YES/NO

Caffeine Intake: Occasional Moderate Heavy

Exercise Level: Occasional Moderate Heavy

Guns present in home? YES/NO

Seat belts used routinely: YES/NO

General stress level: Low Medium High

Advance directive: YES/NO

Gynecological History:

Last Menstrual Cycle: _____

Frequency of Cycle: _____

Duration of Flow: _____

Age of First Period: _____

Age of first child: _____

Current birth control: _____

Age of Menopause: _____

Date of last Pap smear: _____

Date of last mammogram: _____

Location of last mammogram: _____

Obstetric History:

Total Pregnancies: _____

Full Pregnancies: _____

Premature: _____

Miscarriage: _____

Abortions: _____

Twins: _____

List of medications you take on a daily basis:

_____

_____

_____

Surgical History:

Procedure Name:	**Procedure Date:**
_____	_____
_____	_____
_____	_____
_____	_____

Patient Registration Form

Today's Date: _____

Patient Information: **Patient's E-mail: _____**

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

Date of Birth: _____ Social Security # _____ Home Phone: _____

Mailing Address: _____ City: _____ Zip Code: _____

Work Phone: _____ Cell Phone: _____ Patient Referred By: _____

Marital Status: _____ Single _____ Married _____ other (widow, divorced, separated) Patient PCP: _____

Pharmacy: _____ Pharmacy Address: _____

Employer Information:

Employer Name: _____ Employer Address: _____

Occupation: _____ Employer Phone: _____

Emergency Contact Information:

Last Name: _____ First Name: _____ Phone: _____ Relationship: _____

Insurance Information:

Insurance Plan Name: _____ Policy ID: _____ Policy Group ID: _____

Policy Holder Name: _____ Policy Holder DOB: _____ Policy Social Security #: _____

Policy Holder Employer:_____ Policy Holder Employer Address: _____

Please read each of the following statements carefully and sign as your authorization, understanding and agreement to each statement.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process claims to my employer, prospective employer and/or insurance carrier.

Signed: _____ Date: _____

MEDICARE BENEFICIARY ASSIGINMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Dr. Vidalia Butler-Poku, M.D. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed: _____ Date: _____

FINANCIAL OBLIGATION: I herby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently. I further understand that if my account is sent to an outside collection agency, additional collection fees will be assigned by the collection agency.

Signed: _____ Date: _____

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

Signed: _____ Date: _____

ADVANCED DIRECTIVE: Do you have an advance directive (living will/power of attorney)?

_____ Yes _____ No If yes, please provide a copy for our records.

PATIENT COMMUNICATION

May we leave a message on your voice mail or answering machine? _____YES _____ NO

Is there anyone other than yourself that you authorize us to speak with on behalf of your medical care? If so, please list name and relation:

_____ _____

Please Print Name **Relationship**

Do you have any other communication restrictions or authorization that you would like to make known? _____

_____