



PATIENT REGISTRATION FORM

Sample (03/10/2009 ) #000000



Admin - Signed Forms & Letters

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Information

Have you been to RediClinic before? Yes  No

Last Name First Name MI

Gender:  MALE  FEMALE    /   /

Date of Birth

Address Apt. #

City State Zip Code

-    -

Daytime Phone

Email Address

Marital Status:  MARRIED  SINGLE

Emergency Contact Name Relationship

-    -

Emergency Contact Phone

Employer Name

How did you hear about us? (please circle one)

- Family/Friend Former Patient Employer Physician/Emergency Room Community Marketing Newspaper/Magazine In-store Marketing Television Radio Mailer Other: \_\_\_\_\_

Insurance Information

Patient Relation to Insured:

- Self  Spouse  Child  Other

Insurance Provider

Group # Member #

If Other than Self, Complete Below

Policy Holder First Name

Policy Holder Last Name

/    /

Policy Holder DOB

ATTENTION

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Please have your insurance information and picture ID available. Thank You!

Allergies: Check all that apply.

- None  Bee sting  Eggs  Aspirin  Drug \_\_\_\_\_  Drug \_\_\_\_\_  Other \_\_\_\_\_  Other \_\_\_\_\_

Medications: Prescription / Non-Prescription / Vitamins / Birth Control / Herbs

- None  Aspirin  Drug \_\_\_\_\_  Drug \_\_\_\_\_  Drug \_\_\_\_\_  Drug \_\_\_\_\_

Females Only

Pregnant:

- Yes  No

Due Date

Last menstrual period

Last PAP

PATIENT REGISTRATION  
FORM

**Primary Care Physician**

 Do you have a Primary Care Physician?  YES  NO

PCP Name \_\_\_\_\_

PCP City \_\_\_\_\_

PCP State \_\_\_\_\_

PCP Zip Code \_\_\_\_\_

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PCP Phone

PCP Fax

**Purpose of Visit Today**

- Illness/Injury\*\*\*  Immunization  
 Physical Exam  Other \_\_\_\_\_  
 Bloodwork

**\*\*\*Review of Symptoms: Please check all that apply**
**Constitutional**

- Recent fever/sweats  
 Wt loss/gain  
 Fatigue/weakness

**Eyes**

- Change in vision  
 Redness/pain/discharge

**Ears/Nose/Throat/Mouth**

- Difficulty hearing/ringing in ears  
 Congestion/hay fever/allergies  
 Trouble swallowing  
 Ear pain  
 Throat Pain

**Cardiovascular**

- Chest pains/discomfort  
 Palpitations  
 Short of breath with exertion

**Skin**

- Rash  
 New or change in mole

**Neurological**

- Headaches  
 Memory loss  
 Fainting

**Psychiatric**

- Anxiety/stress  
 Sleep problem

Duration of Symptoms? \_\_\_\_\_

**Respiratory**

- Cough/wheeze  
 Coughing up blood

**Gastrointestinal**

- Heartburn/reflux  
 Blood or change in bowel movement  
 Nausea/vomiting/diarrhea  
 Pain in abdomen

**Genitourinary**

- Painful/bloody urination  
 Leaking urine  
 Discharge: penis or vagina  
 Unusual vaginal bleeding  
 Concern with sexual functions

**Musculoskeletal**

- Muscle/joint pain  
 Recent back pain

**Blood/Lymphatics**

- Unexplained lumps  
 Easy bruising/bleeding

**Endocrine**

- Cold/heat intolerance  
 Increase thirst/appetite

**None**

**Medical History:**

Check all that apply at this time.

**General**

- High blood pressure  
 High cholesterol  
 Asthma  
 COPD  
 Heart trouble  
 Diabetes  
 Stroke  
 Thyroid disorder  
 Lung problem  
 Digestive tract disorder  
 Cancer  
 Disease of the kidney  
 Arthritis  
 Liver problem/jaundice  
 Malaria  
 Tuberculosis  
 Nervous disorder

**Surgical History**

- Tonsillectomy  
 Appendectomy  
 Gall bladder surgery  
 Heart surgery or stint  
 Hysterectomy  Tubal  
 Dialysis or indwelling catheter  
 Other: \_\_\_\_\_

 No known problems

**Social**

- None  
 Tobacco (smoking)  
 Alcohol  
 Caffeine

**Family History**

- No known problems  
 Asthma \_\_\_\_\_  
 High blood pressure \_\_\_\_\_  
 Heart trouble \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 Thyroid problem \_\_\_\_\_  
 Cancer \_\_\_\_\_  
 Other: \_\_\_\_\_

\*\* FOR INTERNAL USE ONLY\*\*

 BP: 

 Height: 

 Resp: 

 Weight: 

 Temp: 

 Blood Sugar: 

 Pulse: 

 Oxygen Saturation:



## Consent to Treatment and Acknowledgment of Financial Responsibility Form

g within the scope of practice permitted by state law. I understand that I have the right to consent or to refuse consent to a proposed treatment.

If I am covered by health insurance, I hereby authorize assignment of benefits to RediClinic. To the extent I have no applicable health insurance, I acknowledge and agree that I will be solely responsible for payment in full for all services rendered to me and my dependents. If the services rendered are covered under my health insurance, I acknowledge and agree that I am still responsible for all applicable co-insurance, co-payments, and/or deductibles.

I also understand and agree that any disputes as to whether a service is a covered service under my insurance must be raised with the insurance company, and RediClinic is not the agent or representative of the insurance company.

I understand that there is a cash price available to all patients not using insurance. If I choose to use insurance or Medicare, RediClinic will bill my health plan directly and my financial responsibility will be determined by the terms of my health plan. I understand that under the terms of my health plan, I may owe more than the posted cash price.

I have received the Notice of Privacy Policy.

|   |              |               |
|---|--------------|---------------|
| Name of Patient: (Please Print)   |              | Date of Birth |
| Name of Patient's Representative, if Patient is unable to sign due to age or disability | Relationship | Date          |
| Signature of Patient or Patient's Representative  |              | Date          |

**For Internal Use Only**  
Clinic #

If symptoms do not improve see Primary Care Physician; if your symptoms worsen see your Primary Care Physician immediately or if he/she is unavailable go to the Emergency Department.