

PATIENT REGISTRATION INFORMATION

Name (Last, First Middle)		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Social Security Number
Cell Phone	Home Phone		Work Phone		
Address		City	State	Zip	
Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Age	
<input type="checkbox"/> Employed <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student		Employer and Address			
Name of referring doctor(s) - we'll send a report		#	Fax #		
Onset of current problem	Worker's compensation? <input type="checkbox"/>	Motor vehicle accident? <input type="checkbox"/> State _____	Other accident? <input type="checkbox"/>		
In emergency, contact:		Relationship	Phone		

Race: White Black / African American Asian Hispanic American Indian Other Refused To Report

Email: _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Insurance Carrier's Address		City	State	Zip
Insured	Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Insured's Phone	
ID #	Group #			
Insured's SS #	City	State	Zip	
Insured's Date of Birth	Insured's Sex <input type="checkbox"/> M <input type="checkbox"/> F	Insured's Employer		

OTHER INSURANCE CARRIER

Insurance Carrier's Address _____	City _____	St _____	Zip _____
Insured _____	Relationship <input type="checkbox"/> Self / <input type="checkbox"/> Spouse / <input type="checkbox"/> Child		
ID# _____	Group # _____	Insured's Phone Number _____	
Insured's Address _____	City _____	St _____	Zip _____
Insured's Date of Birth _____	Insured's Sex <input type="checkbox"/> M <input type="checkbox"/> F	Insured's Employer _____	

In consideration of the examination to be provided by our physicians, Drs Porudominsky, Kleinstein and Sierra. I understand that the doctor makes no representations about my condition other than those concerning the problem for which he has been retained. I assign any benefits received from my insurer to Drs Porudominsky, Kleinstein and Sierra. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is also valid. I authorize release of all information necessary to secure payment. Should the doctor's testimony be required with regard to my case, I agree to be responsible for a \$250.00 per hours fee for testimony and preparation I agree to pay any deductible or other balance not paid by my insurer. I understand that a monthly charge of 1% (12% annual rate 12%) and collection costs including attorney's fees may be charged on overdue payments.

Patient's Signature _____ Date _____

IMPORTANT: Please answer the medical questions on the back of this page.

Describe in detail the problem that brings you here today:

List ALL medical problems, operations, and hospital admissions:

Year	Doctor or hospital	Nature of problem

List ALL your usual medications and doses (including any form of aspirin):

NAME AND PHONE NUMBER OF PHARMACY:

To what drugs are you ALLERGIC? None known
 CONSENT TO OBTAIN MEDICATION HISTORY YES OR NO

Please circle YES or NO for each of the following:

Y N Cigarette smoking: <input type="checkbox"/> past <input type="checkbox"/> present	Y N Abdominal pain
Y N Alcohol abuse: <input type="checkbox"/> past <input type="checkbox"/> present	Y N Nausea or vomiting
Y N Drug abuse: <input type="checkbox"/> past <input type="checkbox"/> present	Y N Rectal bleeding or black stools
Y N Any relative with cancer	Y N Recent change in bowel habits
Who _____ What type _____	Y N Blood in urine
Y N Fever or chills	Y N Difficulty voiding
Y N Loss of appetite	Y N Men: Loss of sexual activity
Y N Injury	Y N Women: Missed or abnormal period
Y N Unintentional weight loss	Y N Ankle swelling
Y N Double vision	Y N Backache
Y N Transient visual loss	Y N Joint pain, swelling, stiffness
Y N Jaundice (yellowing of skin or eyes)	Y N Leg pain
Y N Dizziness	Y N Breast lump or nipple discharge
Y N Swollen glands	Y N Varicose veins
Y N High blood pressure	Y N Phlebitis or inflamed vein
Y N Chest pain	Y N Fainting or blackouts
Y N Palpitations	Y N Paralysis
Y N Heart murmur	Y N Numbness
Y N Shortness of breath	Y N Blood transfusions
Y N Wheezing or asthma	Y N Easy bruising or bleeding
Y N Coughing of blood	