



KURT D JONES, MD, FACOG CENTER FOR WOMENS HEALTH

Triple i / Cliniform PATIENT REGISTRATIC

Name _____ SS# _____
 Street Address _____ Date of birth _____ Marital status: S M W Sep I
 City _____ State _____ Zip _____
 Telephone: Home _____ Office _____
 Referred by _____
 Spouse's name _____
 Spouse's employer / address _____
 Emergency contact _____ Tel# _____ Relationship _____

PATIENT EMPLOYER INFORMATION

Employer name _____ Tel# _____
 Employer street address _____ City / State _____ Zip _____
 Patients occupation _____

INSURED PERSON (IF NOT PATIENT)

Name _____ Tel# _____
 Street Address _____ City / State _____ Zip _____
 Relationship to patient _____

INSURANCE

Medicaid # (if applicable) _____ Medicare # (if applicable) _____
 Primary Insurance Company Name _____
 ID # _____ Group # _____ Tel # _____
 Secondary Insurance Company Name _____
 ID # _____ Group # _____ Tel # _____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize Dr. _____ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. _____ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____
(Patient, parent, or guardian)

MISCELLANEOUS NOTES



Name _____ SS# _____

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit: _____

Present medications: _____

Allergies to medications: _____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent: _____

Other physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations (include number of miscarriages and live births): _____

Females only: Are you pregnant, planning a pregnancy or nursing a child? Yes No

Do you smoke? No Yes Cigarettes Pipe Cigars No. of years _____ How much? _____

Interested in stopping? Yes No

Do you regularly drink alcohol? Yes No How many ounces/beers per day? _____

Do you regularly drink coffee? Yes No How many cups per day? _____

Are you under a lot of pressure at work? Yes No Please describe: _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following (check all that apply):

Chest pain/pressure/tightening Asthma Kidney disease

Hypertension Dizzy spells Shortness of breath

Heart attack Cancer TB/Lung disorder

Stroke Diabetes Ulcers

Headaches Arthritis Skin disorders

Glaucoma Difficulty hearing Hepatitis

Allergies or Eczema Glaucoma Cataracts

Depression Memory loss Digestive problems

Blood in stool Hemorrhoids Frequent urinary infections

Other: _____

IMMUNIZATIONS

(Year last received, if known)

Smallpox _____

Tetanus _____

Typhoid _____

Polio _____

Influenza _____

Pneumonia _____

bella _____

Hepatitis _____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CI
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ECZEMA / PSORIASIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK / STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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