St. Mary's Legacy Clinic

NEW PATIENT REGISTRATION FORM

Date: _____ Clinical Site: _____

Last Name _____ First Name _____ Middle Name/Initial _____ Suffix (Jr, Sr) _____

Date of Birth (DOB) _____ Gender __Male __Female Marital Status _____ Social Security # _____

Home Address (Number, Street) _____ City _____ State _____ Zip Code _____

E-mail address _____ Home Phone # _____ Work Phone # _____ Mobile Phone # _____

Race
__ Afro American
__ Asian
__ Caucasian
__ Hispanic
__ Native American
__ Other_____

Ethnicity
__ Hispanic or Latino
__ NOT Hispanic or Latino
__ Unknown

In what country were you born?
_____

What is your religious preference?
_____

Do you have any problems reading, writing or understanding spoken English? __Yes __ No

Other doctors or clinics that you use_____
When is the last time that you saw another doctor or clinic? _____

Preferred Hospital (if any) _____ Preferred Pharmacy (if any) _____

EMPLOYMENT

Are you
__ Employed?
__ Full-Time Student?
__ Part-time Student?
__ Unemployed?
__ Employed Part-time?
__ Seasonally employed?
__ Self-employed?
__ Student/Child?
__ Disabled?
__ Retired?

If you are employed, please provide the following:

Employer Name:_____

Length of time on the job: _____ Job Title: _____

Does your employer offer health insurance? __ Yes ___No

If Yes, are you insured? __ Yes ___No

If you are not insured, please tell us why _____

_____

HOUSEHOLD

No. of people in household ____ Household annual income (if known) _____
How many years of school did you complete? _____
What is your main mode of transportation? _____

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PAST MEDICAL HISTORY

Do you now have or have you ever had a history of the following? Check all that apply.

___ Arthritis	___ Colon Polyps	___ Glaucoma	___ Kidney Disease
___ Asthma	___ Diabetes	___ Heart Disease	___ Stomach Ulcer
___ Cancer	___ Emphysema/COPD	___ High Blood Pressure	___ Stroke
___ Cataracts	___ Epilepsy	___ Other:_____	

PAST HOSPITALIZATIONS: Please list any times you have spent the night in the hospital.

PAST SURGERIES: Please list any surgeries you have had and the year you had them done.

Surgery Type	**Year**	**Surgery Type**	**Year**
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Please list any known medical conditions for these family members:

Father_____ Father's Mother_____ Father's Father_____

Mother_____ Mother's Mother_____ Mother's Father_____

SOCIAL HISTORY

Do you smoke cigarettes? ___Yes ___No If Yes, How many packs per day? _____

Did you ever smoke? ___Yes ___No If Yes, How many packs per day? _____

For how many years did you smoke?_____ When did you quit smoking?_____

Do you use any street drugs? ___Yes ___No If yes, which ones? _____

Do you drink alcohol? ___Yes ___No If yes, how many drinks per day? _____

Do you chew Tobacco? ___Yes ___No If yes, how many cans per day? _____

MEDICATIONS CURRENTLY TAKING (include prescriptions, vitamins, supplements and over-the counter medications.)

Medication Name	*Dose strength*	*Number of times per day*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY ALLERGIES TO MEDICATIONS: _____

ARE YOU ALLERGIC TO LATEX? ___Yes ___No