Patient ID:

RAWHIDE RURAL HEALTH CLINIC
NEW PATIENT REGISTRATION FORM

(Please Type or Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former name(s):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:

P.O. box:	City:	State:	ZIP Code:

Home phone no: ( )	Cell phone no: ( )	Other phone no.: ( )
Occupation:	Employer:	Employer phone no.: ( )

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rawhide Rural Health Clinic or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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RAWHIDE RURAL HEALTH CLINIC

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

PAST MEDICAL HISTORY

Yes or No	Yes or No
Heart Disease	Hyperthyroid
Heart Attack	Kidney Stones
Heart Arrhythmia	Kidney Disease
Atrial Fibrillation	Stroke
Congestive Heart Failure	Gallbladder Disease
Hypertension	Anemia
Vascular Disease	Chronic Back Pain
Diabetes: *Insulin Dependent *Non-Insulin Dependent	Rheumatoid Arthritis
High Cholesterol	Lyme Disease
Lung Disease	Psoriasis
Asthma	Depression
Reflux Disease (GERD)	Osteoporosis
Ulcers	Neuropathy
Cancer (location)	Hypothyroidism
Blood Clots (DVT or PE)	Fibromyalgia
Other:	Colitis

SURGERIES

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ Yes ☐ No

Patient ID:

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS		
Drug Name	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS	
Drug Name	Reaction You Had

SOCIAL HISTORY					
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Soda	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Do you have a FAMILY HEALTH HISTORY of:			Relationship		

Heart disease	Yes	No	
High Blood Pressure	Yes	No	
Diabetes	Yes	No	
Stroke	Yes	No	
Cancer	Yes	No	
Thyroid disease	Yes	No	
Depression	Yes	No	
Blood Clots	Yes	No	
Other:			

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OTHER MEDICAL ISSUES
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐	Skin	☐	Chest/Heart	☐	Recent changes in:
☐	Head/Neck	☐	Back	☐	Weight
☐	Ears	☐	Intestinal	☐	Energy level
☐	Nose	☐	Bladder	☐	Ability to sleep
☐	Throat	☐	Bowel	☐	Other pain/discomfort:
☐	Lungs	☐	Circulation		