Bellevue Health Clinic

Patient Registration Form

Please fill out form completely.

Last Name: ________________________________M.I.__________ First Name:______________________________

Date of Birth: _____/______/___________ Sex: ❑Male ❑Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Address:____Apt#:____________________

City_________________ State_______ Zip: ______________ Email:______________________________________

Home Phone: _______________________ Cell Phone: _________________________

Employer:____ Employer phone: ____________________________

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed [ ] Retired [ ] Student [ ] Other:

Previous PCP: Phone:

Based on government regulations we are required to ask the following information: ❑ I prefer not to answer

Race: ❑American Indian or Alaska Native ❑Asian ❑Black ❑Native Hawaiian or Other Pacific Islander ❑White ❑Other

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino **Preferred Language**: _________________________________

Emergency Contact: ❑ I authorize Bellevue Health Clinic to release health information to my Emergency Contact/s.

Name: ____________________________ Relationship: ___________________ Phone #__________________________

Name: ____________________________ Relationship: ___________________ Phone #__________________________

Insurance Information ❑Self pay

Primary Insurance: ____ Relation to Subscriber: ❑Child ❑Spouse ❑Other________

ID #: ____ Group #: ____

Subscriber Name: _______________________________ Birth Date: ____________ Phone #: ______-_____-_______

Secondary Insurance: _______________________________________ Relation to Subscriber: ❑Child ❑Spouse ❑Other________

ID #: ____ Group #: ____

Subscriber Name: _______________________________ Birth Date: ____________ Phone #: ______-_____-_______

ACKNOLDGEMENT OF REVIEW NOTICE OF PRIVACY PRACTICES

X: ____ Date: ________________________________

Patient/Guardian Signature

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to Bellevue Health Clinic. I also authorize the release of any and all information required in the processing of the claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees. I am financially responsible for non-covered services.

X: ____ Date: ______________________________

Patient/Guarantor Signature

Bellevue Health Clinic Date: ____________________

PATIENT MEDICAL HISTORY

Last Name	First Name	Middle (INITIAL)

Preferred Pharmacy: ☐ **N/A**

Allergies ❑ No Known Allergies

❑ Sulfa Drugs ❑ Adhesive Tape ❑ Wheat ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Contrast Dye ❑ Latex ❑ Penicillin ❑ Peanut

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Cancer, type			
COPD			
Diabetes			
Heart attack/CAD/Heart Failure			
Hypertension			
Kidney disease			
Stroke			
Other			

SOCIAL HISTORY

Occupation: ______________________________ ☐ Disabled (reason ________________________)

☐**Yes** ☐**No -** Do you drink alcohol? (____ drinks) ☐ Daily ☐Weekly or ☐Socially, ☐ Beer ☐ Wine ☐ Liquor _______

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (____ packs/Cigarettes per day) (_____ years) ☐ Vapor ☐ Marijuana

☐**Yes** ☐**No -** Do you use any drugs? Type of drug ________________

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following? ❑ NONE

❑ ADD/ADHD ❑ CAD/Heart Attack ❑ hyperlipidemia ❑ Migraines/headaches
❑ Alzheimer's Disease/Dementia ❑ CHF/congestive heart failure ❑ hypertension ❑ Osteoporosis
❑ Anemia ❑ COPD / Asthma ❑ hyperthyroidism ❑ Pulmonary embolism/Blood clot
❑ Anxiety/Depression ❑ Crohn's disease ❑ hypothyroidism ❑ Seizure disorders
❑ Arthritis ❑ Diabetes Type1 or 2 ❑ irritable bowel syndrome ❑ Sleep Apnea
❑ Atrial fibrillation/Flutter ❑ Fibromyalgia ❑ kidney problems ❑ Stroke/TIA
❑ BPH ❑ GERD/Acid Reflux ❑ Liver disease/hepatitis ❑ Cancer
❑ Chronic pain ❑ Gout ❑ Lupus ❑

For Females: Date of Last Menstrual Period: ________
Date of Last Pap Smear: _____________ Abnormal?______
Date of Last Mammogram: _____________Abnormal? ______

Number of Pregnancies: __________ Miscarriages: ______
Terminations: _______ Living Children: _________
Method/s of Contraception: ________________________

Medications: List any medications you are currently taking (please include over the counter medications):

MEDICATION	DOSAGE	Frequency

Do you have a living will? _____ If yes, please provide us a copy.