Baum 5 Star Healthcare

Patient Registration

Patient name (first & last):_____ _____
Date of Birth: ____/____/____ Gender: M/F/T/other Sexual orientation:_____
Cell Phone #(____)_____-_____ E-Mail:_____
Preferred method of communication: Cell Phone / Text / E-Mail / Mail
Primary Language: English/Spanish/_____ Preferred pharmacy_____
Address:_____
City:_____ State:_____ Zip:_____
Marital Status: M/S/D Social Security #_____-_____-_____

Guarantor (for minors only):
Name: (first & last): _____ Relationship to patient:_____
Address:_____
City:_____ Sate:_____ Zip:_____
Date of birth:____/_____/_____ Cell Phone # (___)_____-_____

Insurance Information

Primary Insurance Carrier:_____ Phone:_____
ID#_____ Group#_____
Name on Policy Holder:_____ DOB: ____ / ____ / _____
Policy Holder Address:_____ Phone # _____
Policy Holder Employer:_____
Employers Insurance Plan? Y / N Relationship to patient: Self / Sponsor / Child

Secondary Insurance Carrier:_____ Phone:_____
ID#_____ Group# _____
Name on Policy Holder:_____ DOB: ____ / ____ / _____
Policy Holder Address:_____ Phone # _____
Policy Holder Employer:_____
Employers Insurance Plan? Y / N Relationship to patient: Self / Sponsor / Child

Emergency Contact Info

Name_____ Relationship to patient_____
Cell Phone # (____)_____-_____ Work # (____)_____-_____
Address_____
City:_____ State:_____ Zip:_____
Name of your previous physician:_____
Phone # (____)_____-_____ Address_____

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Medical History

Patient Name (first & last) :_____ _____
DOB: ____ / _____ / _____

Do you have any of the following medical conditions?

Y / N Diabetes (pills or insulin)
Y / N High Cholesterol/Hyperlipidemia
Y / N Hyperthyroidism
Y / N Insomnia
Y / N Obstructive sleep apnea
Y / N Congestive Heart Failure/CHF
Y / N COPD
Y / N Anemia
Y / N Stroke/CVA
Y / N Hepatitis _A _B _C
Y / N Incontinence
Y / N High Blood Pressure / Hypertension
Y / N Hyperthyroidism
Y / N Atrial Fibrillation
Y / N Depression / Anxiety
Y / N Fibromyalgia
Y / N Asthma
Y / N Migraines/headaches
Y / N GERD/reflux
Y / N Cirrhosis
Y / N Valley Fever / Coccidioidomycosis
Y / N Arthritis
Y / N Cancer (if so what type):_____

Medications

Medication/Name	Dose/Frequency
_____	_____/_____
_____	_____/_____
_____	_____/_____

Any allergies to medication(s)? If yes, what?_____

Surgeries/Dates:

__Pacemaker/Defibrillator __/___/___
__Shoulder surgery-left / right___/___/___
__Finger surgery – left / right____/___/_____
__ Knee surgery - left / right_____/___/_____
__Gastric Sleeve:____/____/____
__Prostate Removal/Prostatectomy___/___/___
__ Uterus removed/Hysterectomy:___/___/___
__CABG____/_____/_____
__ Ovaries removed/Oophorectomy ____/___/___
__ Tonsils removed/Tonsillectomy___/____/____
__ Appendix removed/Appendectomy___/___/____
__ Abdominal surgery____/____/____
__ Gastric Bypass ____/____/_____
__ Cervical spine surgery_____/_____/_____
__Adenoids removed/Adenoidectomy____/____/____
__Gallbladder removed/Cholecystectomy____/____/____
__Wrist Surgery - left / right ____/____/___
__ Hip Surgery - left / right _____/____/___
__ Ankle surgery – left / right ____/___/___
__ Thoracic spine surgery____/____/____
__ Toe surgery - left / right ____/____/____
__ Lumbar spine surgery____/_____/____
__ Foot Surgery - left / right ___/____/___
__ C-section ___/_____/_____

Any other surgeries not listed above:_____

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Women

LNMP/last normal menstrual period:___/____/ ____
Date of last PAP:_____ / _____ / _____ __Normal __Abnormal __Biopsy
Number of pregnancies/Gravida:_____ Number of live births/Para:_____
Date of last Mammogram:____/_____/___ __Normal __Abnormal
Form of contraceptive: Depo injection/pills/patch/ nuva ring/IUD/_____
Date of last Bone scan/ DEXA scan:___/___/___ Facility Name:_____
Date of last Colonoscopy:___/___/___ ___Normal __ Abnormal Doctor's Name:_____

Vaccine / Date Given:
Date of Flu vaccine:___/____/_____ Date of pneumonia vaccine:___/_____/_____
Date of Shingles vaccine:___/____/___ Date of Tetanus/DTap/Adacel:___/____/_____
Are you up to date with childhood vaccines? Y / N

Social History:

Y / N Any use of tobacco products? If so how many cigarettes per day?_____
Y / N Any use of alcohol? If so, _ Daily _ Weekly _ Socially and how many?_____
Y / N Any use of Marijuana? If so, _Daily _Weekly _Socially and how many?_____
Y / N Any use of recreational drugs? (Please list name of drug and how often):
_____

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Medical Records Release Form

Patient Name:_____ Date of Birth:_____/_____/_____
Person requesting records and relationship:_____
Home Phone # (____)_____-_____ Daytime Phone # (____)_____-_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entry listed below.

Limitation on the information you may release subject to this release form are as follows:
_____
_____

Release my protected health information to the following person(s) entity:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

I do _____ do NOT___ give permission for there records to be faxed to the above entity

_____ _____
Patients Signature Date