Big Sandy Medical Center
Patient Registration

(Please Print)

Today's date:	Primary Provider:	Onset of symptoms:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Married/ Divorced / Separated / Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Race and Ethnicity:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Physical address: Mailing address:	Social Security no.:	Home phone: ( )

City	State	Zip Code:	Cell Phone: ( )

Occupation:	Employer:	Employer phone no.: ( )

Email Address:	Are you a tobacco user?	If so, what kind?

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

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

INSURANCE INFORMATION

Relationship to patient:

Primary Insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

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

Is this patient covered by other insurance? ❑ Yes ❑ No

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

Primary Emergency Contact: Physical Address:	Relationship to patient:	Home phone no.:	Work phone no.:
Secondary Emergency Contact: Physical Address:	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 Big Sandy Medical Center or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

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Family History

Father	☐ Alive- Age____ ☐ Deceased-Age____	Present Health or Cause of Death:		
Mother	☐ Alive-Age____ ☐ Deceased-Age____	Present Health or Cause of Death:		
Brothers	Number Living:	Health:	Number Deceased:	Cause of Death:
Sisters	Number Living:	Health:	Number Deceased:	Cause of Death:
Children	Number Living:	Health:	Number Deceased:	Cause of Death:

Circle any illnesses which have occurred in any of your **Blood Relatives:**

Diabetes Cancer Bleeding Tendency Kidney disease Tuberculosis Heart disease Stroke High blood pressure anxiety

Personal Medical History

Check symptoms you currently have or have had in the last 12 months (All information is strictly confidential)

General
- ☐ Chills
- ☐ Depression/anxiety
- ☐ Dizziness/fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness or numbness in: (circle)

Arms Hips
Back Legs
Feet Neck
Hands Shoulders

Genito-urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular
- ☐ Chest pain
- ☐ High/low blood pressure
- ☐ Irregular/rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye, Ear, Nose, Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache or discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision–Flashes/halos

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Erectile dys.
- ☐ Lump in testicle
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal pap
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date last Period_____
Last Pap_____
Last Mammogram_____
Are you Pregnant? Y N
Number of Children_____

Describe any serious illnesses or communicable diseases you have had in the past:

List any surgeries you have had:

Allergies:

Current Medications:

Pharmacy_____ Phone # _____

Health Habits:

Caffeine: How much/day _____ Alcohol: How often_____

Street Drugs: Type _____ How often_____ Exercise: Type_____ How often_____

Tobacco: Type_____ How often_____