Patient Registration

Patient Information			
Last Name:	First Name:	MI:	Date of Birth:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated			Sex: ☐ Male ☐ Female
Address:			Apt #:
City:	State:		Zip:
Home Phone:	Cell Phone:		Work Phone:
Social Security Number:	Email Address:		

We can TEXT patients some information regarding LAB Results, Prescriptions, Medications, Referrals, and other general medical information. Would you like to be notified this way?

☐ Yes ☐ No If yes, please select preferred number: ☐ Home ☐ Cell ☐ Work

Insurance Information		
Primary Insurance Name:	Policy/ID No.:	Group No.:
Secondary Insurance Name:	Policy/ID No.:	Group No.:

Emergency Contact Information		
Name:	Phone No.:	Relationship:

Pharmacy Information			
Name:	Phone No.:		
Address:	City:	State:	Zip:
Mail Order Pharmacy Information			
Name:	Phone No.:		

Disclosure Information - Who may we share your protected health information with?		
Name:	Phone No.:	Relationship:
Name:	Phone No.:	Relationship:
Name:	Phone No.:	Relationship:

PF-200 Acknowledgement of Receipt of Notice of Privacy Practices.

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed by E.S.Romanelli,MD,PA. I understand I am entitled to receive a copy of your Notice of Privacy Practices.

Name of Patient (Print):	Signature:	Date:
Signature of Patient Representative:	Relationship to Patient:	

Inclement Weather Notice

In the event of inclement weather, we will follow the policies of the Irving School District.

Your Su Clinica
We specialize in your health Nos especializamos en su salud

Medical History

Last Name: _____ First Name: _____ D.O.B: _____/_____/_____

Check all that apply:

Drug Allergies: _____ **Reaction**: _____
_____ _____
_____ _____

Non-Drug Allergies: Eggs_____ Tape_____ IPV Dye_____ Seafood_____ Other_____
Childhood Illnesses: None significant _____ ADD _____ Asthma _____ Eczema _____
Nasal allergies _____ Other _____

Adult Illnesses	Diagnosis date
Arthritis	_____/_____/_____
Asthma	_____/_____/_____
Bipolar Disorder	_____/_____/_____
Cancer Of: _____	_____/_____/_____
Stroke	_____/_____/_____
Depression	_____/_____/_____
Diabetes	_____/_____/_____
High Cholesterol	_____/_____/_____
GERD/Heartburn	_____/_____/_____
Gestational Diabetes	_____/_____/_____
Glaucoma	_____/_____/_____
Headaches	_____/_____/_____
Heart Attack	_____/_____/_____
CHF/Heart Failure	_____/_____/_____
High Blood Pressure	_____/_____/_____
Thyroid Disease	_____/_____/_____
Pneumonia	_____/_____/_____
Osteoporosis	_____/_____/_____
Other: _____	_____/_____/_____

Hospitalizations (Year : Illness)
_____
_____
_____

Surgeries
_____
_____
_____

Prescribed Medications
_____
_____
_____

Non Prescription Medications
_____
_____
_____

Health Maintenance/Prevention

When was the last time the following tests were performed?

Cholesterol	_____/_____/_____	Flu Vaccine	_____/_____/_____
Prostate/Rectal Exam	_____/_____/_____	Tetanus	_____/_____/_____
PSA	_____/_____/_____	Hepatitis B(3 shots)	_____/_____/_____
Mammogram	_____/_____/_____	TB test/PPD	_____/_____/_____
Dexa Scan/Osteoporosis	_____/_____/_____		
Pap Smear	_____/_____/_____	**What Colon test was done?**	
Pneumonia(Pneumovax)	_____/_____/_____	Flex sigmoidoscopy	When: ____/____/____
Colon Screening	_____/_____/_____	Colonoscopy	When: ____/____/____
		Stool Cards	When:____/____/____

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Social History
Marital Status _____
Occupation _____

Alcohol Consumption
None / Never a heavy drinker _____
Past heavy drinker but quit _____
Drink Socially _____
How many drinks (or beers) per day? _____
How many days per week do you drink? _____

Tobacco Consumption
None / Never _____
I currently smoke _____
How many packs per day? _____
How many packs per week? _____
I live with a smoker _____
I quit smoking _____ # of years ago
If you quit smoking, how many packs per day did you smoke and for how many years?
_____ per day for _____ years.

Substance Abuse / Illegal drug use
None / Never _____

Illegal Drugs used in the past / recovered
Patient admits to:
Marijuana _____
Cocaine _____
Intravenous drug use _____
Narcotics _____
Amphetamines _____
Anabolic Steroids _____
Frequency?
Frequently _____
Infrequently _____
Rarely _____

Exercise
Yes _____ No _____
Frequency?
Frequently _____
Infrequently _____
Rarely _____

Family History

Mother's History
Healthy _____
Deceased due to _____
Significant for:
Diabetes _____
She developed it at the age of_____
High blood pressure _____
Cancer of the _____
She developed it at the age of_____
Stroke _____
Depression _____
Bipolar Disorder _____
Glaucoma _____
Cholesterol abnormality _____
Osteoporosis _____
Thyroid disease _____
Heart disease _____

Father's History
Healthy _____
Deceased due to _____
Significant for:
Diabetes _____
He developed it at the age of_____
High blood pressure _____
Cancer of the _____
He developed it at the age of_____
Stroke _____
Depression _____
Bipolar Disorder _____
Glaucoma _____
Cholesterol abnormality _____
Osteoporosis _____
Thyroid disease _____
Heart disease _____

Other relatives with significant disease

Relationship: _____ Disease: _____
_____ _____
_____ _____
_____ _____