

PATIENT REGISTRATION
Jefferson City Medical Group

Please Print (Legal)

Patient Name:				
<small>(First)</small>	<small>(Middle)</small>	<small>(Last)</small>	<small>(Nickname)</small>	
Physical Address:				
City, State, Zip:				
Billing Address:				
City, State, Zip:				
Home Phone:	Cell Phone:	Emergency Contact Person:	Relationship:	Emergency Phone:
- -	- -			- -
Age:	Birth Date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Other	
Social Security Number: - -		Ethnicity: <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown		
Patient Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> Unknown				
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Finnish <input type="checkbox"/> Czech <input type="checkbox"/> Italian <input type="checkbox"/> Other				
Email Address:				
Patient's Employer:			Occupation:	
Address:			Work Phone: - -	Ext:
Referring Physician:		Primary Physician:		
Spouse:	Social Security Number: - -		Birth Date: / /	
Spouse's Employer:			Phone: - -	
Address:				
Nearest Relative: (not living with you)		Relationship:	Phone: - -	
Person Responsible For Payment <i>(Only complete if different than patient)</i>				
Name:				
Address:				
Home Phone Number: - -			How Related:	
Employer:		Work Phone Number: - -		
Occupation:			Social Security Number: - -	
Insurance Information <i>Must present Insurance card.</i>				
Insurance Company Name:				
Policy Number:	Group Number:		Subscriber Name:	
Patient's relationship to subscriber? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
Social Security Number: - -	Birth Date: / /			
Secondary Insurance Company: (If Applicable)				
Policy Number:	Group Number:		Subscriber Name:	
Patient's relationship to subscriber? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
Social Security Number: - -	Birth Date: / /			
<i>SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR:</i>				
✓			Date: / /	

Patient Name _____ Age _____ Date of Birth _____ Pt. # _____ Date _____

Drug Allergies

Current medications:

Reason for today's visit: (chief complaint)

Current or past problems with: (Review of systems)

	Yes	No	(if yes, explain)
General Health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/muscles/joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____

Females: are you pregnant? __yes __no planning to become pregnant? __yes __no

Family History: (Past family & social history)

Mother: living/deceased _____ age _____ Father: living/deceased _____ age _____

Check following medical conditions that have occurred in your family:

<u>Disease</u>	<u>Mother</u>	<u>Father</u>	<u>Blood Relative</u>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

Do you frequent tanning salons? ___ no ___yes-frequency _____

Do you sunbathe? ___ no ___yes-frequency _____

Do you smoke? ___ no ___yes-frequency _____ Occupation _____

Reviewed _____ Date _____

Stephanie Hose, M.D.

Robyn McCullem, M.D.