PATIENT INSURANCE REGISTRATION FORM

PATIENT'S NAME ____________________ SOCIAL SECURITY # ____________
(Last, First, Middle Initial)

ADDRESS ____________________ CITY ____________ STATE ______ ZIP ________

PHONE (Home) ____________ PHONE (Daytime) ____________ PHONE (Cell) ____________

EMAIL: ____________ DATE OF BIRTH ________ SEX (circle): MALE FEMALE MARITAL STATUS (circle): S / M / D / W

*THE FOLLOWING MUST BE INDICATED SINCE THEY ARE GOVERNMENT MANDATED QUESTIONS
***RACE (circle): AMERICAN INDIAN/ALASKA NATIVE ASIAN BLACK /AFRICAN AMERICAN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER WHITE**
***ETHNICITY (circle): HISPANIC NON-HISPANIC PREFERRED LANGUAGE:**

PRIMARY CARE PHYSICIAN NAME: ____________________ PHONE# ____________
(as stated on insurance card if applicable)

EMPLOYER NAME: ____________________ EMPLOYER PHONE: ____________

EMPLOYER ADDRESS ____________________ CITY ____________ STATE ______ ZIP ________

SPOUSE'S NAME ____________ SPOUSE'S PHONE ____________ SPOUSE'S DATE OF BIRTH ________

SPOUSE'S ADDRESS ____________________ CITY ____________ STATE ______ ZIP ________

RESPONSIBLE PARTY INFORMATION (circle) SELF SPOUSE CHILD PARENT STUDENT OTHER **IF NOT SELF, COMPLETE FIELDS BELOW;**

NAME (Last, First) ____________________ TELEPHONE ____________

ADDRESS ____________________ CITY ____________ STATE ______ ZIP ________

EMERGENCY CONTACT: ____________________ PHONE: ____________ CELL: ____________

RELATIONSHIP TO PATIENT ____________ ADDRESS OF CONTACT ____________________

INSURANCE INFORMATION (Please write information about the patient's insurance here.)

PRIMARY INSURANCE CO. NAME ____________ SECONDARY INSURANCE CO. NAME ____________

INSURED'S ID NO. ____________ INSURED'S ID NO. ____________

GROUP PLAN NO. ____________ GROUP PLAN NO. ____________

INSURANCE CO. ADDRESS ____________ INSURANCE CO. ADDRESS ____________

RELATIONSHIP TO INSURED ____________ RELATIONSHIP TO INSURED ____________

NAME OF INSURED ____________ NAME OF INSURED ____________

ADDRESS OF INSURED ____________ ADDRESS OF INSURED ____________

D.O.B. OF INSURED ________ SEX OF INSURED ________ D.O.B. OF INSURED ________ SEX OF INSURED ________

PHARMACY NAME: ____________ ADDRESS ____________

PHONE NUMBER: ____________ PHARMACY FAX: ____________

HOW WERE YOU REFERRED TO OUR OFFICE?(circle):SELF/ANOTHER PATIENT/WINTHROP EMERGENCY ROOM/EMPLOYER/DOCTOR/OTHER (please explain)

IF REFERRED BY OTHER, PLEASE EXPLAIN: ____________________

IF REFERRED BY A DOCTOR; PHYSICIAN NAME: ____________ PHONE# ____________

IF CLAIM IS NO FAULT OR WORKERS COMPENSATION PLEASE NOTIFY THE RECEPTIONIST FOR THE APPROPRIATE FORMS...

DID INJURY OCCUR AT SCHOOL? (circle):YES NO **WAS INJURY DURING A SCHOOL SPORT**(circle):YES NO **NAME OF SPORT:** ____________
DATE OF INJURY: ________ SCHOOL NAME: ____________ SCHOOL PHONE#: ____________
SCHOOL INSURANCE CARRIER NAME: ____________________
SCHOOL INSURANCE ADDRESS: ____________ CITY, STATE & ZIP: ____________

X ____________________ ____________
PATIENT (or authorized signature) DATE

PERSONAL HISTORY:

Please list any present or past medical problems (including heart disease, cancer, and diabetes):

____

____

Have you had surgery? Yes No If yes, please state type and date: ____________

____

____

Do you have **ALLERGIES** to medication or foods? ____________

____

List any **MEDICATIONS** that you are presently taking: ____________

____

____

Do you smoke? Yes No If yes, please state amount of packs per day: ____________

What type of **BIRTH CONTROL** do you use? ____________

When was your last PAP TEST: ____________

MENSTRUATION:

At what age was your first period? ____________

Are your periods regular (every 28-30 days)? ____________

How long does your period last? ____________

When was your last menstrual cycle? ____________

Do you have cramps during your period? ____________

Are your periods mild, moderate or heavy? ____________

OBSTETRICAL HISTORY:

Number of children? ____________ Number of pregnancies? ____________

Was your delivery vaginal or caesarean section? ____________

FAMILY HISTORY:

List any history of heart disease, cancer, diabetes, and state how you are related to that person:

____

____

CHIEF COMPLAINT: (What type of problem are you presently experiencing?):

____

____

____

Patient Signature: ____________ Date: ____________

GYNECOLOGIC INTAKE HISTORY

NAME:______________________ BIRTH DATE:____/____/____ DATE:____/____/____

ADDRESS:______________________

CITY______________________ STATE/ZIP:______________________

HOME TEL:(   )______________________ WORK TEL:(   )______________________

EMPLOYER:______________________ INSURANCE:______________________

NAME OF SPOUSE/PARTNER:______________________ REFERRED BY:______________________

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

1. CONSTITUTIONAL	CURRENTLY	PAST	NOTES
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2. EYES			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
3. ENT/MOUTH			
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
4. CARDIOVASCULAR			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Difficult breathing on exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
5. RESPIRATORY			
Wheezing	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Cough, chronic	☐	☐	
6. GASTROINTESTINAL			
Diarrhea, frequent	☐	☐	
Bloody stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	
7. GENITOURINARY			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress incontinence	☐	☐	
Abnormal periods	☐	☐	
Painful intercourse	☐	☐	
8. MUSCULOSKELETAL			
Muscle weakness	☐	☐	

9. SKIN/BREAST	CURRENTLY	PAST	NOTES

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN		
Pain in breast	☐	☐
Discharge	☐	☐
Masses	☐	☐
Rash	☐	☐
Ulcers	☐	☐
10. NEUROLOGICAL		
Dizziness	☐	☐
Seizures	☐	☐
Numbness	☐	☐
Trouble walking	☐	☐
11. PSYCHIATRIC		
Depression	☐	☐
Crying, frequent	☐	☐
12. ENDOCRINE		
Dry skin	☐	☐
Abnormal thirst	☐	☐
Hot flashes	☐	☐
13. HEMATOLOGIC/LYMPHATIC		
Bruises, frequent	☐	☐
Cuts do not stop bleeding	☐	☐
Enlarged lymph nodes	☐	☐
14. ALLERGIC/IMMUNOLOGIC		
Allergies	☐	☐
Drugs, other	☐	☐

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO		YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Venereal Disease			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		

OPERATIONS/HOSPITALIZATIONS

Reason	Date	Reason	Date

INJURIES/ILLNESSES

Type	Date	Type	Date

LAST IMMUNIZATION OR TEST

	Date		Date
Tetanus		Pneumonia	
Flu Shot		TB Skin Test	

OB/GYN HISTORY

	Number		Number
Births		Abortions	
Miscarriages		Living children	

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY

illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY

Habits				
Smoking	Yes ☐	No ☐	Packs per day______	Years__________
Alcohol	Yes ☐	No ☐	Drinks per day______	Drinks per week_____
Drug Use	Yes ☐	No ☐		
Seat Belt Use	Yes ☐	No ☐		
Regular Exercise	Yes ☐	No ☐		

Personal Profile

Marital Status Married ☐ Single ☐ Widowed ☐ Divorced ☐

Number of Living Children________________

Number of people in household____________

School Completed High School ☐ College ☐ Graduate Degree ☐ Other ☐

Current or most recent job____

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of patient:____

Date reviewed by physician with patient:_____________________________

Physician Signature:____

Annual Review of History

Date reviewed:______________________ Physician Signature:______________________

Date reviewed:______________________ Physician Signature:______________________

Date reviewed:______________________ Physician Signature:______________________

Date reviewed:______________________ Physician Signature:______________________

RICHARD I. ROBERTS, MD, P.C.

PATIENT'S NAME ______________________________ **(PLEASE PRINT)**

I. INSURANCE WAIVER

INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES:

In consideration of services rendered by Richard I. Roberts, MD, P.C. to the undersigned patient, the undersigned promise(s) to pay to Richard I. Roberts, MD, P.C. any co-payment, coinsurance or other charges required to be paid by my health insurance coverage.

ASSIGNMENT OF BENEFIT PROCEEDS:

I request that payment of authorized HMO/third-party payor/governmental agencies (Medicare and Medicaid) benefits be made either to me or on my behalf to Richard I. Roberts, MD, P.C. for services furnished to me by the provider.

AUTHORIZATION TO RELEASE RECORDS:

I hereby authorize Richard I. Roberts, MD, P.C. to release to my insurer/HMO/third-party payor, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

MEDICARE PATIENTS: Upon receipt of the Medicare Explanation of Benefits, we will bill you for the difference between what Medicare has paid us and the amount Medicare legally allows us to charge you. We will bill your secondary if you have one. **ACCEPTED ASSIGNMENT DOES NOT EXEMPT YOU FROM PAYMENT OF BALANCE DUE.**

Private Insurance: PAYMENT IS EXPECTED AT THE TIME OF VISIT.

______________________________ ______________________________
Signature of Patient or Authorized Representative Date

II. PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have been provided with a copy of Richard I. Roberts, MD, P.C.'s Privacy Notice.

______________________________ ______________________________
Signature of Patient or Authorized Representative Date

____
Relationship to Patient