MEDICAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

City ______

State ______ Zip ______

E-mail ______

Sex ☐ M ☐ F Age ______ Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ______

Patient Employer/School ______

Employer/School Address ______

______

Employer/School Phone (_____) ______

Spouse's Name ______

Birthdate ______ SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

2 INSURANCE

Who is responsible for this account? ______

Relationship to Patient ______

Birthdate ______ SS# ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

INSURANCE ASSIGNMENT AND RELEASE

I am being treated by Dr. Kleinman & I give permission to release my medical records. ______

I certify that I have insurance coverage with

______
Name of Insurance Company(ies)

and assign directly to Dr. Yehuda E. Kleinman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read a copy of Dr. Kleinmans notice of privacy practice.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

Yehuda E. Kleinman, M.D.
______
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ Date ______ Relationship to Patient

3 PHONE NUMBERS

Home Phone (_____) ______

Cell Phone (_____) ______

Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT:

Name ______

Home Phone (_____) ______

Cell Phone (_____) ______

Work Phone (_____) ______ Ext ______

4 FAMILY HISTORY

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

☐ Diabetes ☐ Cancer ☐ Bleeding tendency
☐ Kidney disease ☐ Tuberculosis ☐ Heart disease
☐ Stroke ☐ High blood pressure ☐ Nervous illness
☐ Allergy ☐ Arthritis ☐ Gout
☐ Other

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– O V E R –

5 MEDICAL HISTORY

Check (✓) symptoms you currently have or have had in the past year. (All information is strictly confidential)

GENERAL

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ 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

SKIN

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

Are you pregnant?_____________

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations____

MEDICAL BACKGROUND

Is your condition related to ☐ Employment ☐ Auto Accident ☐ Other ______________________________

Reason for visit ____

How and when did it start:____

Were Xrays taken_________ If so, where & when ______________________________________

Activity or time of day when problem seems worse ___________________________ better______________________

Pain Scale: (0-10, 10 being the worst) ____

Are you taking or have you ever taken medicine for this problem_________ If yes, which medication_________________________ Did it help______

MEDICATIONS/ALLERGIES

List medications you are currently taking _______________________

____

Pharmacy Name_______________________________________

Phone (_____) _______________________________________

List allergies to medications or substances _______________________

____

____

HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine_________________
- ☐ Street Drugs ______________
- ☐ Tobacco_________________
- ☐ Other___________________

Check (✓) if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other___________________

6 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ Signature of Patient, Parent, Guardian or Personal Representative

_______________________ Date

____ Please print name of Patient, Parent, Guardian or Personal Representative

_______________________ Relationship to Patient

____ Reviewed by

_______________________ Date