PATIENT REGISTRATION FORM

PATIENT INFORMATION (please print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security _____-_____-_____ ☐ Female ☐ Male ☐ Transgender Date of Birth _____/_____/_____

Race (Circle one) American Indian/Alaska Native, Asian, native Hawaiian/pacific Islander, Black/African American, White, Hispanic, Other, Declined

Ethnicity (Circle One) Hispanic or Latino, Non-Hispanic or Latino, Declined

Language Preferred (Circle One) English, Spanish, Indian, Japanese, Chinese, Korean, French, German, Russian, Other

Email Address _____

Phone Numbers: Home _____Cellular _____ Work_____Ext. _____

Address: _____

City, State, Zip _____

Employment Status (Circle One) Employed, Full time Student, Part-Time Student, Retired, Self-Employed, Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Emergency Contact Relationship to Patient _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION

☐ Check here if same as above

Responsibility Party Name (Last) _____ (First) _____ (Middle) _____

Social Security Number _____/_____/_____ ☐ Female ☐ Male Date of Birth _____/_____/_____

Phone Numbers Work _____ Home _____ Cellular _____

Address _____

City, State, Zip _____

Employer _____ Phone Number _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION_____(provide your insurance card to the front desk at check-in)

Name of Insured _____ Relationship to Patient _____

Insured Employer Name _____

Insurance Company/Phone Number _____ (____)_____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Insured Date of Birth _____/_____/_____ Insured Social Security Number _____/_____/_____

Insurance Company Address _____

SECONDARY INSURANCE INFORMATION_____(provide your insurance card to the front desk at check-in)

Name of Insured _____ Relationship to Patient _____

Insured Employer Name _____

Insurance Company/Phone Number _____ (____)_____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ ☐ Female ☐ Male

Insured Date of Birth _____/_____/_____ Insured Social Security Number _____/_____/_____

Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (Or Responsible Party) Signature _____ **Date** _____

Occupational and Family Medicine of South Texas
dba Kirkwood Medical Associates
4001 Preston Avenue Ste #110 Pasadena, TX 77505
281-249-2273 phone 281-249-2282 fax

Patient Name:_____ DOB:_____/_____/_____

MEDICAL PROBLEMS

Have you had any of the following? (Circle any that apply)

High blood pressure	heart disease	heart attack	stroke
Diabetes	arthritis	HIV/Aids	breast cancer
Colon cancer	anemia	hepatitis/jaundice	asthma
Liver/pancreas problems	thyroid disease	tuberculosis	sickle cell
Urinary infections	emphysema	kidney stones	seizures
Abnormal PAP	blood transfusions	STD's	other

If other, describe them_____
_____

PAST SURGERIES

Have you had any of the following (Circle any that apply)

Appendix	spine/joint	hysterectomy	thyroid	lung	D&C
Hernia	gallbladder	tubal ligation	tonsillectomy	heart	C-Section
Orthopedic	cataract L/R	breast biopsy L/R	kidney L/R	colon	ovaries

If other, describe them_____
_____

Marital Status:_____

WOMAN ONLY

Do you suspect that you are pregnant? Yes No
If yes, Due Date:_____
Are you Nursing? Yes No
Taking Birth Control Pills/Shot? Yes No
Last Menstrual Period: _____

SOCIAL HISTORY

Do you currently or have you ever used tobacco products? Yes No
What type? _____ Amount used daily?_____
Do you consume alcohol? Yes No
Amount consumed daily? _____

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FAMILY HISTORY

	Age	**Disease**	**Deceased/Cause of Death**
Mother:			
Father:			
Sibling 1:			
Sibling 2:			

MEDICATIONS

Are you taking any medication Prescribed, Non-Prescribed or Natural? Yes No
If yes, list them. Please indicate dosage and directions.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES

Are you allergic to any medications? Yes No
If yes, please give name of medication and kind of reaction.

_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY

Name of Pharmacy _____
Address _____
Phone Number _____ Fax Number _____

_____ _____
Patient Signature Date

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Patient Name: _____ Date: _____

Thank you for choosing our office for you medical care. Our providers and staff are dedicated to provide excellent quality healthcare to each of our patients. Kirkwood Medical Associates, Company Care and Bayside Urgent Care would like to invite you to participate in our Patient Satisfaction Survey. Our survey will be sent to you via email, after your visit. This survey will help us to ensure that you have a pleasant experience and let us know how to improve to serve you better. Your time spent filing out the survey is greatly appreciated.

Email Address:_____

Please let us know how you heard about our clinic (circle one)

- Work
- Google
- Insurance
- Newspaper
- Health Fair
- Yellow Pages
- Word of Mouth
- Hospital Referral
- Physician Referral
- Chamber of Commerce
- Resource Guide
- Drive by
- Other: _____