PREMIER HEALTHCARE SERVICES

New Patient Registration

Patient Information:

Name (Last, First): _____ Sex: (M / F) DOB: _____/_____/_____

Address: _____

Street City State Zip Code

Phone (Home): _____ (Work): _____ (Cell): _____

Email (Portal Access): _____

Pharmacy Information:

Preferred Pharmacy: _____ Phone #: _____

Previous Primary Care Physician (PCP): _____

Emergency Contact Name: _____ Relationship to Patient: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Insurance Information:

Primary Insurance: _____

Policy: _____

Group #: _____

Secondary Insurance: _____

Policy: _____

Group #: _____

Policy Holder Name (If other than self): _____ DOB: _____

Patient Relationship to Policy Holder: _____

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Patient Name: _____ DOB: _____

Medical History

Allergies: _____

Medication	Dosage	Frequency

Past Medical Conditions: Please list any medical problems.

_____

_____

_____

Surgical History: Please list all surgeries and approx. dates.

_____

_____

_____
_____

Family History: Please list any medical conditions and indicate who in the family has/had them.

_____
_____
_____
_____
_____

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Patient Name: _____ DOB: _____

Date of last Annual Physical: _____

Date of last Fasting Blood Work: _____

Date of last Colonoscopy: _____

Date of last Tetanus Injection: _____

Date of last Flu Shot: _____

Females Only

Date of last Menstrual period: _____ Date of last Pap Smear: _____

Date of last Dexa Scan: _____ Date of last Mammogram: _____

Social History:

Caffeine Intake? _____ If so, what type? _____ How many cups per day? _____

Tobacco use: Do you smoke? _____ If so, how many cigarettes per day: _____ Years: _____

Alcohol use: Do you drink alcohol? _____ If so, how many drinks per week? _____

Drug use: Any history of illicit drug use? _____ If so, what type? _____ How Often? _____

Exercise: How often do you exercise per week? _____