American Health Center Patient Registration Form Date of Appointment: _____

Patient Information

Patient's First Name | Middle Name | Last Name (As it appears on Insurance Card or ID)

Sex | Marital Status | Date of Birth (Age) | Social Security Number

Patient's Address | City | State | ZIP

Home Phone | Mobile Phone | Email Address

Referred By | Primary Care Physician | Primary Care Physician's Phone

Pharmacy | Pharmacy Phone | Pharmacy Address

Patient Employer/School Information

Employer/School | Occupation | Employer/School Phone

Employer/School Address | City | State | ZIP

Emergency Contact

Emergency Contact Name | Emergency Contact Phone | Relationship to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company | Plan

Plan Number | Group Number | Insured's Employer/School

Insured's Name (As it appears on Insurance Card or ID) | Relationship to Patient | Insured's Phone Number

Insured's Address | City | State | ZIP

Insured's Social Security Number | Insured's Birthday

Responsible Party

Billing Name (If other than Patient) | Phone | Relationship to Patient

Billing Address | City | State | ZIP

American Health Center Ltd. has my authorization to disclose Medical Records to:

Name: _____ Number: _____ Relationship: _____

Signature of Patient or Authorize Guardian | Date

☐ I am OK with receiving texts to confirm appointments at no extra charge.

☐ I am OK with receiving emails to confirm appointments and communicate.

American Health Center Patient Registration Form Date of Appointment: _____

Patient Name _____ Gender _____ Age _____

What brings you to the office today?

_____

_____

_____

_____

_____

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

_____

_____

_____

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Local Anesthetics ☐ Codeine ☐ Sulfa

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism	☐ Back Problems	☐ Ear Problems	☐ Hepatitis- A, B, or C	☐ Measles	☐ Skin Disorder
☐ Allergies	☐ Bleeding Disorder	☐ Eating Disorder	☐ High Blood Pressure	☐ Migraines	☐ Stomach Ulcer
☐ Anemia	☐ Blood Disease	☐ Epilepsy	☐ High Cholesterol	☐ Osteoporosis	☐ Substance Abuse
☐ Anxiety Disorder	☐ Blood Transfusion	☐ Glaucoma	☐ Joint Disorder	☐ Pneumonia	☐ Thyroid Disorder
☐ Arthritis	☐ Cancer	☐ Gout	☐ Kidney Disorder	☐ Polio	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Heart Disease	☐ Liver Disorder	☐ Rheumatic Fever	☐ Venereal Disease
☐ AIDS/HIV	☐ Depression	☐ Heart Problems	☐ Lung Disease	☐ Stroke	

Hospitalizations & Surgeries

Reason	Date

Women Only:

# of Pregnancies	# of Miscarriages	# of Abortions	# of Living

Last Pap Smear	Last Mammogram	Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism	☐ Cancer	☐ Joint Disorder
☐ Allergies	☐ Depression	☐ Kidney Disease
☐ Alzheimer's	☐ Diabetes	☐ Liver Disorder
☐ Anemia	☐ Epilepsy	☐ Lung Disease
☐ Anxiety	☐ Genetic Disorder	☐ Migraines
☐ Arthritis	☐ Glaucoma	☐ Psychiatric Disorders
☐ Asthma	☐ Heart Disease	☐ Osteoporosis
☐ AIDS/HIV	☐ Hepatitis	☐ Stroke
☐ Bleeding Disorder	☐ High Cholesterol	☐ Substance Abuse
☐ Blood Disorder	☐ High Blood Pressure	☐ Thyroid Disorder

Details:

_____

_____

_____

_____

_____

_____

Lifestyle Factors

Are You Sexually Active?

☐ Yes ☐ No # of Partners in the past year ____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you? ☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of Years ____ # of packs/day ____

Do you smoke now?

☐ Yes ☐ No # of packs/day ____

Do you use recreational drugs?

☐ Yes ☐ No Types:_____ # of Times/week____

How much alcohol do you drink per week?

# of drinks/week_____

How much caffeine do you drink per day?

# of drinks/day_____

How often do you exercise?

# of times/week _____