American Health Center Patient Registration Form Date of Appointment: _____

Patient Information (As it appears on Insurance Card or ID)

First Name | Middle Name | Last Name

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/Student

Emergency Contact

Emergency Contact Name | Emergency Contact Phone | Relationship to Patient

Primary Health Insurance

Insurance Company | Plan Number | Group Number

Primary Policyholder | Relationship to Patient

Insured's Phone Number | Insured's Birthday

Insured's Address | City | State | ZIP

Responsible Party if under 18

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

Patient Name _____ Date of Birth _____

What brings you to the office today? Do you have any other concerns you would like to address?

_____

_____

_____

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical exam _____

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Any known allergies? Please list them and your reaction.

Name	Reaction

Hospitalizations & Surgeries

Reason	Date

Women Only:

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

Last Pap Smear	Last Mammogram	Birth Control Method

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	

Family History

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

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

_____

Patient Signature