4660 Wilkens Ave,
Suite 205,
Baltimore MD
Tel: 410-650-4121
Fax: 877-763-4971

NEW PATIENT REGISTRATION FORM

Please complete this form to the best of your knowledge. This is to ensure a fast appointment process with us. We can try to enter information in your electronic chart and also try to obtain your medical record. We would also like to verify your insurance benefits before your visit to the office. Thank you.

1-PATIENT INFORMATION				
Last Name First Name MI			Sex:	Home Phone:
Address:			Social Security#	
City, State:	Zip:	DOB:		Marital Status:
Employer Info:		Job Title:		Work Phone:
Name and phone number of emergency Contact:				
Email address:		Cell Phone:		May we correspond by email? ☐Yes ☐No
Please specify Ethnicity: _____________ ☐ Hispanic ☐ Non- Hispanic ☐ Language: ________________ Race: ☐ White ☐ Black ☐ Hispanic ☐ Other: ________________				
2-PRIMARY CARE PHYSICIAN INFORMATION				
Referred by:		Reason for referral:		
Address:			Office phone: Office Fax:	
3-REFERRING PHYSICIAN INFORMATION				
Referred by:		Reason for referral:		
Address:			Office phone: Office Fax:	
4-YOUR PRIMARY INSURANCE				
☐ Medicare ☐PPO ☐HMO				
5-FINANCIAL RESPONSABILITY				
Name of person financially responsible:		DOB:		Relation to patient:
Address:		Social Security		Phone:

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6- INSURANCE INFO

Primary Insurance Name, ID Number, Group Number

Name of Insured person, DOB, Phone, address, relation to patient

7- MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

☐ Anemia
☐ Arthritis
☐Asthma
☐ Bleeding/ Blood Disorder
☐ Breasts cancer
☐ Cancer: _______
☐ Cataracts
☐ Colitis
☐ Depression
☐ Constipation
☐ Emotional/Mental Illness

☐ Emphysema
☐ Epilepsy/seizures
☐ Glaucoma
☐ Hay Fever
☐ Heart Problems
☐ Hepatitis Jaundice
☐ High Blood pressure
☐ HIV/AIDS
☐ Lupus
☐ Polymyalgia Rheumatica (PMR)
☐ Kidney Stones

☐ Liver disease
☐ Osteoporosis
☐ Migraine Headache
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis/TB
☐ Rheumatoid Arthritis
☐ Other: _____________

8- SURGICAL HISTORY

Surgical Procedures /Serious Injuries /Illnesses	Year	Physician	Hospital

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☐ Have you been hospitalized in the past year, if so why?____

Any Previous Fractures ? ☐Yes ☐No Describe: ____

Any other serious injuries? ☐Yes ☐No Describe: ____

9- MEDICATIONS

Pharmacy Name: __________________________________ Phone: ____________ Fax: ________________

Address: ____

List all medications you are currently taking which have been ordered by a doctor (including inhalers)and all over the counter drugs. Please list prescribed medication first .. right side describe medication you have stop using and why.

Name of Medicine/Dose/ Frequency	Medicine you stop using WHY
1.	1.
2.	2.
3.	3.
4.	4.

10- ALLERGIES

☐ Medications/ list describe: ____

☐ Food ☐ Animals ☐ Latex ☐ Tape ☐ pollen ☐ Eggs ☐ iodine ☐ Nuts

11-SOCIAL HISTORY

Patient's Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Prefer not disclose ☐No. of Children

Do you drink caffeinated beverages? ☐Yes ☐No Cups/glasses per day? ___________________

Do you Smoke? ☐ Never ☐ Past ☐ Current? ☐ Cigarettes ☐ Tobacco

Year quit? ________ Number of years' smoke? ________Average packs day/week? ____________

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Do you drink alcohol? ☐Yes ☐No Number per week____ Do you drink every day? ☐Yes ☐ no
Has anyone ever told you to cut down on your drinking? ☐Yes ☐ no
Have you evert thought you have a problem with drinking? ☐Yes ☐ no

Do you use drugs for reasons that are not medical? ☐Yes ☐No If Yes, please list: ____________________

Your most recent Height ________________ Weight: ________________________

12 - FAMILY HISTORY

Do you know any relatives who had: (Check and give relationship)?

☐ Cancer___________ ☐ Heart Problems_________ ☐Asthma___________ ☐ Goiter ___________ ☐ Leukemia _______	☐ Rheumatic Fever ____________ ☐ Diabetes _________ ☐ Epilepsy _________ ☐ Tuberculosis_____ ☐ Cataracts_________	☐ Glaucoma ________ ☐ Kidney Disease ___________ ☐ Pneumonia ______ ☐ Psoriasis ________ ☐ Stroke ___________	☐ High Blood Pressure __________ ☐ Anemia__________ ☐ HIV/AIDS ________ ☐ Emphysema _____ ☐ Colitis ___________

Patient's Name: ____________________________________ Date: _____________ Physician initials:___________

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