Registration Form

Patient Name____DOB:______________________
Last First M

Home Address:____City:________________________State:_________Zip:_________

Telephone # Home:_______________________________Cell:____________________________Contact Preference: Home Cell
(Please Circle)

SS#:_______-_____-_______ Male Female Single Married Divorced Widowed
(Please Circle) (Please Circle One)

Primary Language Spoken:__________________________ Race:____________________________ Ethnicity:____________________

Employer:____ Main Phone Number:____

Primary Insurance Carrier:____ Policy ID:_________________________________

Type of Plan: HMO PPO POS Other Insurance Carrier Phone #: (   )____________________ If Other:________________
(Please Circle One)

Second Insurance Carrier:____ Policy ID:____

Type of Plan: HMO PPO POS Other Insurance Carrier Phone #: (   )____________________ If Other:_________________
(Please Circle One)

Emergency Contact:_______________________________ Emergency Contact Address:____

Emergency Contact Phone #:___________________________ Emergency Contact Relationship:________________________________

How did you hear about Soni Family Practice?_____________________________

Soni Family Practice offers a secure and convenient way to access your health care information such as updating your personal information, making appointments, viewing upcoming appointments, retrieving test results, etc. via the patient portal.
Would you like to have access to the patient portal? Yes No
(Please Circle One)

_________ I consent to having my Immunization/Vaccination records retrieved.
(Please Initial)

_________I consent to having my medication history retrieved.
(Please Initial)

Insurance Payment Agreement & Authorization

I hereby authorize my insurance company to pay any benefits directly to Soni Family Practice, PLLC. I also understand and agree that any sum of money paid under this service shall be credited to my account and in the event the sum is insufficient to payout my account, I agree to be responsible for any non-covered services and balances not paid by my insurance within 30 (thirty) days. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature: ____ Date:__________________________

Release of Information

I request and authorize Dr. Soni of Soni Family Practice, PLLC to obtain any necessary medical records from the hospital, physician's office, laboratory, or diagnostic centers. I understand that my records have a privileged and confidential status. I am waiving that status and authorizing the release of information regarding clinical information.

Signature: ____ Date:__________________________

Receipt of Notice of Privacy Practice Acknowledgement Form

I, ____________________________________, have received and reviewed a copy of Soni Family Practice, PLLC's Notice of Privacy Practices.

Health History Questionnaire

Patient Last Name:___________________________ Patient First Name:_______________________ DOB:_______

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, don't answer it. Add any notes you think are important.
Main reason for today's visit: ____
Other concerns: ____

Allergies

Are you allergic to any medications: ☐ Yes ☐ No
List anything that you are allergic to (medications, food, bee stings etc.) and how each affects you.

Allergy	Reaction
1.__________________________	__________________________
2.__________________________	__________________________
3.__________________________	__________________________

Which pharmacy do you use: ___________________________________ City: ____________________________________

Medications

Please list all the medications you are taking including inhalers, oxygen, chemotherapy, prescribed drugs, over the counter drugs and vitamins.

Drug Name	Dosage	How Often	When Started
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Immunization History

Immunizations and most recent date:

□ Chickenpox	Date: ___________	□ Meningococcus	Date: _________	□Typhoid	Date:_________
□ Flu shot	Date: ___________	□ MMR (Measles, Mumps, Rubella)	Date: _________	□Smallpox	Date:_________
□ Gardasil/HPV	Date: ___________	□ Pneumonia	Date: __________	□Pneumococcal	Date:_________
□ Hepatitis A	Date: ___________	□ Tdap (tetanus and pertussis)	Date: __________		
□ Hepatitis B	Date: ___________	□ Tetanus	Date: __________		
		□ Zostavax (Shingles)	Date: __________		

Hospitalizations: (Other than operations)

Reasons Approximate Dates

____
____
____

Serious Injuries:

Reasons Approximate Dates

____
____
____

Past Surgical History

Surgery	Reason	Year	Hospital
1.			
2.			
3.			
4.			

Patient Name: ________________________________ **Date of birth**:____________

Obstetric and Gynecological History (Women only)

Last PAP smear___________
Last mammogram___________
Age of first menstrual period___________
Date of last menstrual period or age of menopause___________
Number of pregnancies: _______ Births: _______ Living_______
Miscarriages: _______ Abortions: _______
□ Cesarean sections if yes, then number: _______
□ Bleeding between periods
□ Heavy periods
□ Extreme menstrual pain
□ Vaginal itching, burning, or discharge

□ Wake in the night to go to bathroom
□ Hot flashes
□ Breast lump or nipple discharge
□ Painful intercourse
□ Sexually active
Current sexual partner is □ Female □ Male
Do you use condoms □ Yes □ No
Other birth control methods used: ___________
□ Interested in being screened for STD'S
□ Breast Self Exam

Past Medical History (Please check all that apply)

□ Alcohol Overuse
□ Amputation
□Anemia
□ Anxiety Disorder
□ Arthritis
  □ Osteo □ Rheumatoid
□ Asthma
□ Bleeding Disorder (specify)__________
□ Blood Clots (or DVT)
□ Cancer (Specify)___________
□Cardiac Arrhythmias
  Pacemaker ________
□ Chronic Bronchitis
□ Colitis
  Specify:________
□ COPD
□ Coronary Artery Disease
□ Claustrophobic
□ Depression

□ Diabetes – I
□ Diabetes – II
  □ Insulin □ Non-Insulin
□ Dialysis
□ Emphysema
□ Falls
□ Gout
□ Heart Attack
□Other Heart Disease (CHF)
□ Hepatitis
□ Hiatal hernia or Reflux Disease
□ HIV or AIDS
□ High Cholesterol
□ High Blood Pressure
□ Kidney Disease
□ Kidney Stones
□ Leg/Foot Ulcers
□ Liver Disease (Specify):________

□ Migraine Headache
□ Mumps
□ Nervous Breakdown
□ Neuropathy
□ Osteoporosis
□ Ostomies
□ Overactive Thyroid
□ Paralysis
□ Polio
□ Pulmonary Embolism
□ Reflux or Ulcers
□ Seizures
□ Sleep Disorder
□ Stroke
□ Tuberculosis
□ Vascular Disease
□ Other

Other conditions: ____
Have you ever had a cardiac stress test □ Yes □ No If so when:_____________
Do you have a history of drug addiction □ Yes □ No

PERSONAL HABITS:

1) Have you ever smoked? Yes No If Yes, are you a regular smoker now? Yes No
   Have you used chewing tobacco? Yes No If Yes, number of yrs. ______ If No, when did you quit?______
2) Do you regularly drink alcohol? Yes No If Yes, how often:____________________
3) Have you ever used any of the following? Marijuana LSD Heroin Cocaine Speed Other:_____________

Family Health History

Relation	Alive?	Age	Significant Health Problems
Grandmother (Maternal)	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Grandfather (Maternal)	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Grandmother (Paternal)	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Grandfather (Paternal)	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke
Father	Y/N	____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke

Patient Name: _______________________________ **Date of birth**: ___________

Family Health History (cont'd)

Mother Y/N ____ □ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke

Brother/Sister Y/N ____ □ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke

Brother/Sister Y/N ____ □ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke

Other: __________ Y/N ____ □ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart disease □ Hypertension □ Osteoporosis □ Stroke

PREVENTATIVE SERVICE HISTORY

Preventive Services	Date Received	Findings and Recommendations
Bone Mass Measurement (Density)		
Cardiovascular Disease Screening > Cholesterol > LDL > EKG	 _____________ _____________ _____________	Hypercholesterolemia _____ Hyperlipidemia ______ Other _____________ EKG Results: _____________________
Colorectal Cancer Screening > Flexible Sigmoidoscopy > Barium Enema > Colonoscopy (not high risk) > Fecal Occult Blood Test	 _____________ _____________ _____________ _____________	
Diabetes Screening > Hg A1C > Foot Exam > Eye Exam	 _____________ _____________ _____________	 Cataracts: Yes No Other: _____________________
Glaucoma Screening		Glaucoma: Yes No
Prostate Cancer Screening > Digital Rectal Exam (DRE) > Prostate Specific Antigen Test (PSA)		

____ ______________________

Patient/Guardian/Parent Signature Date

Date reviewed:____________________ Physician Signature:______________________________