

PATIENT REGISTRATION

the office of
Wesley Beth Reiss, D.O.



GENERAL INFORMATION

▼ PATIENT NAME	▼ TODAY'S DATE
_____	____/____/____
▼ STREET ADDRESS	▼ DATE OF BIRTH
_____	____/____/____
▼ CITY, STATE, ZIP	▼ MARITAL STATUS
_____	Sin. Mar. Wid. Div. Sep.
▼ HOME PHONE (include area code)	▼ CELL PHONE (if available)
(____) _____	(____) _____
▼ WORK PHONE	▼ SOCIAL SECURITY #
(____) _____	_____
▼ OCCUPATION / EMPLOYER	

▼ WHO REFERRED YOU TO DR. REISS?

▼ SPOUSE'S NAME	▼ SPOUSE'S DATE OF BIRTH
_____	____/____/____
▼ SPOUSE'S OCCUPATION / EMPLOYER	▼ SPOUSE'S PHONE (Work)
_____	(____) _____

▼ IF PATIENT IS UNDER 18, NAME OF PARENT / GUARDIAN

▼ EMERGENCY CONTACT (other than spouse)	▼ RELATIONSHIP
_____	_____
▼ EMERGENCY CONTACT PHONE	▼ CONTACT ADDRESS
(____) _____	_____

PRIMARY PHYSICIAN

▼ PRIMARY PHYSICIAN'S NAME	▼ CITY AND PHONE #
_____	_____
Does Dr. Reiss have your permission to contact the above doctor in reference to your treatment, to better coordinate your care? ➤ YES <input type="checkbox"/> NO <input type="checkbox"/>	
▼ NAME & SPECIALTY OF ANY OTHER PHYSICIAN DR. REISS SHOULD CONTACT?	▼ CITY AND PHONE #
_____	_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Dr. Reiss for services rendered by her. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Reiss to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

MEDICARE

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

X	____/____/____
▲ PATIENT SIGNATURE (unless younger than 18 – see below)	▲ DATE
X	_____
▲ PARENT / GUARDIAN (signature)	▲ PARENT / GUARDIAN (print)

MAIN REASON FOR VISIT >

OTHER HEALTH CONCERNS

FAMILY HISTORY	CAUSE OF DEATH (& AGE)	Follow the lines across the page and mark the appropriate boxes																	
		HIGH BLOOD PRESSURE	HEART DISEASE	CANCER	DIABETES	ARTHRITIS	EPILEPSY	STROKE	ASTHMA	HAYFEVER	KIDNEY DISEASE	GLAUCOMA	MIGRAINE	MENTAL ILLNESS	ALCOHOLISM	ANEMIA	BLEEDS EASILY	PSORIASIS	ECZEMA
FATHER																			
MOTHER																			
BROS. / SIS.																			
BROS. / SIS.																			
BROS. / SIS.																			
FATHER'S RELATIVES																			
MOTHER'S RELATIVES																			

HOSPITAL ADMISSIONS		Women – Do not include normal pregnancies.	
YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

ACCIDENTS / INJURIES		Other than those in "Hospital Admissions" above. Include automobile, bicycle, sports, or childhood traumas.	
YEAR	ACCIDENT OR INJURY	YEAR	ACCIDENT OR INJURY

MEDICATIONS						List all medications you are now taking. Include over-the-counter Rx.		
NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN			

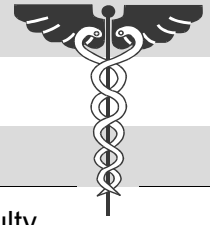
DRUG ALLERGIES:

DIETARY SUPPLEMENTS		List all vitamins, herbals, and other nutritional supplements you are now taking.	
NAME (include manufacturer and dosage if possible)	NAME (include manufacturer and dosage if possible)	NAME (include manufacturer and dosage if possible)	NAME (include manufacturer and dosage if possible)

FOOD ALLERGIES:

MEDICAL HISTORY

the office of
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PATIENT NAME

▼ PATIENT NAME

▼ TODAY'S DATE

/ /

CHECK ALL THAT APPLY

- | | | |
|--|---|--|
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Sleeping difficulty |
| <input type="checkbox"/> Ringing in ear | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Ear infection – frequent | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Urine infections - frequent | <input type="checkbox"/> Memory loss |
| | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Failing vision | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Moodiness |
| <input type="checkbox"/> Double or blurred vision | <input type="checkbox"/> Control of urination | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Eye infections – frequent | <input type="checkbox"/> Decreased force in urination | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Recent hair loss |
| <input type="checkbox"/> Cataracts | | <input type="checkbox"/> Venereal Disease |
| | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Herpes <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Weight loss – recent | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Allergies (airborne) | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Hoarseness – prolonged | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Rheumatic |
| | <input type="checkbox"/> Seizures | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Pneumonia / Pleurisy | <input type="checkbox"/> Stroke | <input type="checkbox"/> T.B. |
| <input type="checkbox"/> Bronchitis / Chronic cough | <input type="checkbox"/> Tremor, Hands shaking | |
| <input type="checkbox"/> Asthma / Wheezing | <input type="checkbox"/> Numbness, Tingling sensations | <input type="checkbox"/> Alcohol _____ oz. / week |
| Shortness of breath: | <input type="checkbox"/> Headaches - frequent | <input type="checkbox"/> Smoking _____ packs / wk |
| <input type="checkbox"/> On Exertion <input type="checkbox"/> Lying Flat | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Coffee / Tea _____ cups / day |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> High blood pressure | | |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Back pain - recurrent | |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Bone fracture | |
| | <input type="checkbox"/> Joint injury | |
| <input type="checkbox"/> Loss of appetite - recent | <input type="checkbox"/> Foot pain | |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Cold numb feet | |
| <input type="checkbox"/> Indigestion or heartburn | <input type="checkbox"/> Swollen Ankles | |
| <input type="checkbox"/> Persistent Nausea | <input type="checkbox"/> Leg pain when walking | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Varicose veins | |
| <input type="checkbox"/> Peptic ulcers | <input type="checkbox"/> Phlebitis | |
| <input type="checkbox"/> Abdominal pain - chronic | | |
| <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Rashes | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hives | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Psoriasis | |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Eczema | |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Severe allergic reactions to ▼ | |
| <input type="checkbox"/> Hemorrhoids | | |
| <input type="checkbox"/> Hernia | | |

Women:

Date of Last Pap Test _____

Date of Last Mammogram _____

Menstrual History:

Age of onset _____

Regular Irregular

Pain Cramps w/ menstrual flow

Number of Pregnancies _____

of Live Births _____

of Miscarriages _____

of Terminated _____

Birth Control method ▼

Flushing, Menopause

IMMUNIZATIONS – Year of Last Injection: _____ Pneumonia _____ Flu _____ Tetanus
_____ Diphtheria _____ Measles _____ Mumps _____ Rubella _____ Polio _____ Hepatitis