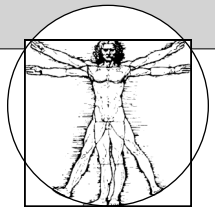
PATIENT REGISTRATION

the office of
Wesley Beth Reiss, D.O., P.C.



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) ( )

WORK PHONE ( )

CELL PHONE (if available) ( )

E-MAIL ADDRESS (to be used for practice updates and product information as you request)

OCCUPATION / EMPLOYER

S.S. #

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 - *IF DIFFERENT FROM SPOUSE*

RELATIONSHIP

EMERGENCY CONTACT PHONE ( )

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 ☐ NO ☐

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.

PATIENT SIGNATURE

DATE / /

PARENT / GUARDIAN (print)

PARENT / GUARDIAN (signature)

OVER ↺

MAIN REASON FOR VISIT ➤

OTHER HEALTH CONCERNS

FAMILY HISTORY

Follow the lines across the page and mark the appropriate boxes ➤

	CAUSE OF DEATH (& AGE)	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)

MEDICAL HISTORY

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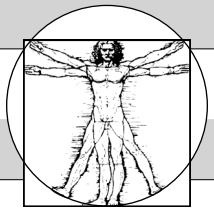

PATIENT NAME

PATIENT NAME _____

TODAY'S DATE ____/____/____

CHECK ALL THAT APPLY

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infection – frequent
- ☐ Dizzy Spells

- ☐ Failing vision
- ☐ Double or blurred vision
- ☐ Eye infections – frequent
- ☐ Glaucoma
- ☐ Cataracts

- ☐ Nose bleeds
- ☐ Sinusitis
- ☐ Sore throat
- ☐ Hayfever
- ☐ Allergies (airborne)
- ☐ Hoarseness – prolonged

- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
  Shortness of breath:
  ☐ On Exertion ☐ Lying Flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart Murmur
- ☐ Palpitations

- ☐ Loss of appetite - recent
- ☐ Difficulty swallowing
- ☐ Indigestion or heartburn
- ☐ Persistent Nausea
- ☐ Vomiting
- ☐ Peptic ulcers
- ☐ Abdominal pain - chronic
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Diverticulosis
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Hernia

- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Urine infections - frequent
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Control of urination
- ☐ Decreased force in urination
- ☐ Kidney stones

- ☐ Chronic fatigue
- ☐ Weight loss – recent
- ☐ Anemia
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Convulsions
- ☐ Seizures
- ☐ Stroke
- ☐ Tremor, Hands shaking
- ☐ Numbness, Tingling sensations
- ☐ Headaches - frequent
- ☐ Arthritis, Rheumatism
- ☐ Gout

- ☐ Osteopenia ☐ Osteoporosis
- ☐ Back pain - recurrent
- ☐ Bone fracture
- ☐ Joint injury
- ☐ Foot pain
- ☐ Cold numb feet
- ☐ Swollen Ankles
- ☐ Leg pain when walking
- ☐ Varicose veins
- ☐ Phlebitis

- ☐ Rashes
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Severe allergic reactions to ➘

_____

- ☐ Depression
- ☐ Nervousness
- ☐ Sleeping difficulty
- ☐ Memory loss
- ☐ Mental illness
- ☐ Moodiness
- ☐ Phobias

- ☐ Recent hair loss
- ☐ Venereal Disease
  ☐ Herpes ☐ Chiamydia
- ☐ Chicken Pox
- ☐ Polio
- ☐ Mumps
- ☐ Measles
- ☐ German Measles
- ☐ Rheumatic
- ☐ Scarlet Fever
- ☐ T.B.

- ☐ Alcohol _____ oz. / week
- ☐ Smoking _____ packs / wk
- ☐ Coffee / Tea _____ cups / day

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, Menopausal symptoms

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

DONE