Patient Registration Form

Download the form to your desktop, fill it out, "Save As" the completed form to your desktop, print it out and bring it in with you to your appointment, or email it back to us. *Please note that email is NOT guaranteed to be a secure method to send information, and there is a risk your information will be intercepted.*

PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________ SSN: ______________

Street Address: ____

City: ______________________ State: ______________ Zip: ______________

Mailing Address: ____

City: ______________________ State: ______________ Zip: ______________

Email Address: ____

Phone Number: ☐ (H) ______________ ☐ (W) ______________ ☐ (C) ______________

Please check preferred method of phone contact above. May we leave a detailed message? ○ Yes ○ No

Tribal Affiliation: ○ Yes ○ No Name of Tribe: ______________________

Would you allow a blood transfusion: ○ Yes ○ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

EMERGENCY CONTACT

Name: ______________________ Relationship: ______________________

Street Address: ____

City: ______________________ State: ______________ Zip: ______________

Phone Number: (H) ______________ (W) ______________ (C) ______________

May we discuss the health of the patient with this person? ○ Yes ○ No

PRIMARY CONTACT

This is the main communication point of contact between patient and staff when questions or concerns arise. This contact will need to be included on the Release Form you'll fill out at your first appointment.

Name: ______________________ Phone Number: ______________________

Street Address: ____

City: ______________________ State: ______________ Zip: ______________

INSURANCE INFORMATION

If subscriber is someone other than yourself, please indicate their name, your relationship to them, and their date of birth

1-Company: ______________________ ID: ______________ Group: ______________

Subscriber: ○ *Self* ○ *Other - relationship:* ______________________ Date of Birth: ______________

2-Company: ______________________ ID: ______________ Group: ______________

Subscriber: ○ *Self* ○ *Other - relationship:* ______________________ Date of Birth: ______________

3-Company: ______________________ ID: ______________ Group: ______________

Subscriber: ○ *Self* ○ *Other - relationship:* ______________________ Date of Birth: ______________

PHARMACY BENEFIT COVERAGE

Company: ______________________ Phone: ____________ ID: ________________

PHARMACY INFORMATION

Pharmacy: ____

Street Address: ____

City: ______________________________ State: ____________ Zip: ____________

Phone Number: ______________________ Fax Number: ______________________

PHYSICIAN INFORMATION

Primary Care Physician: __________________ Phone: ____________ Fax: ____________

Street Address: ____

City: ______________________________ State: ____________ Zip: ____________

Oncologist/Specialist: ____________________ Phone: ____________ Fax: ____________

Oncologist/Specialist: ____________________ Phone: ____________ Fax: ____________

Oncologist/Specialist: ____________________ Phone: ____________ Fax: ____________

Oncologist/Specialist: ____________________ Phone: ____________ Fax: ____________

Oncologist/Specialist: ____________________ Phone: ____________ Fax: ____________

FAMILY HEALTH HISTORY

Please place an "X" in the relevant boxes, with a "D" for deceased. Please designate the type, e.g. sibling and grandparent.

Condition	Self	Mother	Father	Sibling (B / S)	Grandparent (MGM / MGF, PGM / PGF)
Cancer (type)					
Diabetes					
Heart Disease					
Hypertension					
Osteoporosis					
Stroke/Clot Disorder					

HOSPITALIZATIONS/SURGERIES

Hospitalization	Year	Reason	Surgeries	Year	Reason

Last Mammogram Date: ______________________ Where Performed: ___________________________________

Last Pap Date: ______________________________ Where Performed: ___________________________________

Last Menstrual Date: _________________________

Last Colonoscopy Date: ______________________ Where Performed: ___________________________________

Last PSA Lab Date: ___________________________ PSA Result: ____

ALLERGIES TO MEDICATION

Medication	Reaction	Medication	Reaction

CURRENT MEDICATIONS/SUPPLEMENTS

Medication/Supplement	Dose/Frequency	Medication/Supplement	Dose/Frequency

ALCOHOL/TOBACCO/CAFFEINE USE

Please mark the following, and fill in amounts where required

Alcohol: ☐ Beer ☐ Wine ☐ Spirits *Amount and frequency* ______________________________

Tobacco: ☐ Cigarette ☐ Chew ☐ Cigars *Packs, frequency, and duration* ______________________________

Caffeine: ☐ Coffee ☐ Tea ☐ Soda *Amount and frequency* ______________________________

MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Please write "C" for current symptoms or "P" for past symptoms and provide date where applicable.

	General
	Fatigue
	Weight Loss
	Weight Gain
	Fever / Chills
	Night Sweats
	Weakness

	Skin
	Rash
	Itching
	Dryness
	Color Changes
	Moles
	Excessive Sweat
	Hair Loss
	Nail Changes
	Eczema / Psoriasis
	Easy Bruising

	Immunological
	Swollen Glands / Lymph Nodes
	Increase Infections
	Autoimmune Disease

	Blood
	Anemia/Other Low Blood Counts
	Bleeding Disorders
	Blood Transfusion(s) (Dates ________________________)

	Lungs
	Cough
	Wheezing
	Short of Breath
	Asthma
	Bronchitis
	Painful Breathing
	Sputum Production / Bloody Sputum
	Tuberculosis Exposure
	Positive TB Skin Test

	Heart
	Hearth Murmur
	Palpitations
	Chest Pain
	Ankle Swelling
	Hypertension
	High Cholesterol

	Gastrointestinal
	Heartburn / Reflux
	Constipation
	Diarrhea
	Nausea / Vomiting
	Poor Appetite
	Hemorrhoids
	Black or Bloody Stool
	Abdominal Pain
	Change in Stool
	Gall Stones
	Hernia

	Endocrine
	High Blood Sugar / Diabetes
	Thyroid Problems
	Intolerance to Heat
	Excessive Thirst or Urination
	Excessive Sweating

	Musculoskeletal
	Joint Pain
	Muscle Tension
	Back Pain
	Muscle Cramps
	Bone Pain
	Osteoporosis / Osteopenia

	Neurological
	Dizziness
	Vertigo
	Headaches
	Tingling / Numbness
	Tremors
	Impaired Balance / Coordination
	Memory Loss

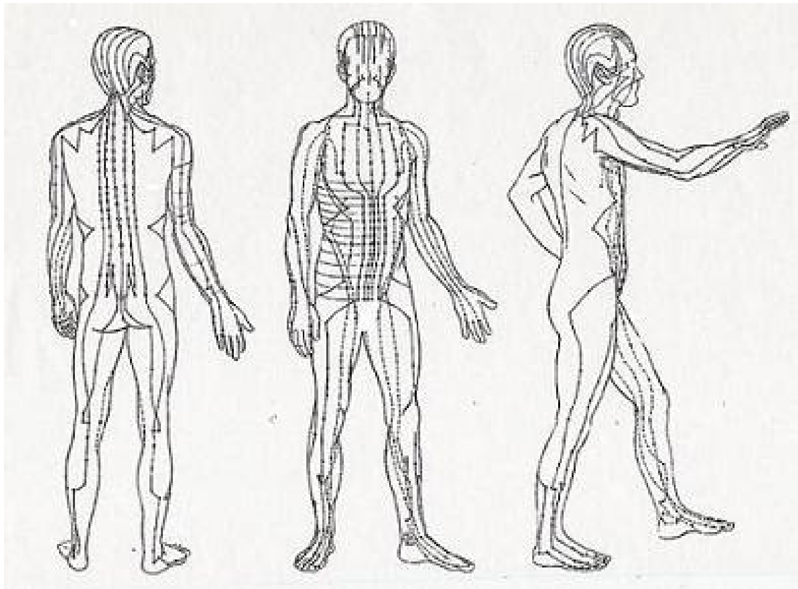
	Gynecological
	Still Having Periods
	# of Pregnancies ___________
	# of Deliveries __________
	Last Gyn Exam Date: ___________
	Last Mammogram Date: _________
	Hormone Therapy

	EENT
	Eye Pain
	Eye Discharge
	Vision Changes
	Glasses / Contacts
	Double Vision
	Glaucoma
	Ear Infections
	Post Nasal Drip
	Sinus Congestion
	Hay Fever
	Bloody Nose
	Mouth Sores
	Bleeding Gums
	Sore Throat
	Difficult to Swallow

	Urinary
	Painful Urination
	Weak Urine Stream
	Blood in Urine
	Kidney Infections
	Nighttime Urination
	Leaking Urine
	Bladder Infection

	Psychological
	Anxiety
	Depression
	Mood Swings

	Other



HOW DID YOU HEAR ABOUT US

Please fill in the source where appropriate

☐ Ad on KING ☐ Ad on KONG ☐ Attended talk by Salish or a Salish provider

☐ Print Ad (*Where?* ______________________) ☐ Friend/Family Member (*Who?* ______________________)

☐ Other ______________________________

Check box if you have a: ☐ Living Will ☐ Power of Attorney ☐ Advance Directive

(Please Provide Copies - you may send them with this form)

Patient Name: ______________________________ Date of Birth: ______________

Patient Signature: ______________________________ Date: ______________