Patient Registration Form

Date of Appointment: ____________

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)
Sex / Marital Status	Date of Birth (Age)	Social Security Number
Patient's Address	City	State / Zip
Home Phone	Mobile Phone	Email Address
Referred by	Primary Care Physician	Primary Care Physician Phone
Pharmacy / Pharmacy Phone	Pharmacy Address	

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone
Employer/School Address	City	State / Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan	
Plan Number / Group Number	Insured's Employer/School	
Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number
Insured's Address	City	State / Zip
Insured's Social Security Number / Insured's Birthdate		

Secondary Health Insurance

Insurance Company	Plan	
Plan Number / Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient
Address	City	State / Zip

Signature of Patient or Authorized Guardian ____________ Date ____________

Name: Age: ________ Gender: ____________ Date of Appointment: ____________________

Reason for Visit

What brings you to the office today?

Have you ever had any of the following Gastroenterological symptoms? (Please check all that apply)

- [ ] Abdominal Pain
- [ ] Anal Pain
- [ ] Bleeding (Black, Red, or Maroon Stool)
- [ ] Change in Appetite
- [ ] Change in Bowel Habits
- [ ] Constipation
- [ ] Diarrhea
- [ ] Difficulty Swallowing
- [ ] Excessive Gassiness
- [ ] Gluten Intolerance
- [ ] Heartburn/Acid Reflux
- [ ] Jaundice (Yellow Skin, Dark Urine)
- [ ] Lactose Intolerance
- [ ] Nausea
- [ ] Pain when swallowing
- [ ] Vomiting
- [ ] Weight Gain
- [ ] Weight Loss

Past Medical History

- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Anxiety Disorder
- [ ] Appendectomy
- [ ] Arthritis
- [ ] Asthma
- [ ] AIDS / HIV
- [ ] Back Problems
- [ ] Blood Disorder (including clots)
- [ ] Blood Transfusion
- [ ] Cancer Type: ____________
- [ ] Celiac Disease
- [ ] Colon Cancer Polyps
- [ ] Crohn's Disease
- [ ] Diabetes
- [ ] Diverticulitis
- [ ] Depression
- [ ] Duodenal Ulcer
- [ ] Ear Problems
- [ ] Eating Disorder
- [ ] Epilepsy
- [ ] Frequent Urinary Tract Infections
- [ ] Groin Hernia
- [ ] Heart Disease
- [ ] Hemorrhoids
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] Hiatal Hernia
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Irritable Bowel
- [ ] Joint Disorder
- [ ] Kidney Disorder
- [ ] Liver Disorder
- [ ] Lung Disease
- [ ] Migraines
- [ ] Mouth Ulcer
- [ ] Obesity Surgery
- [ ] Osteoporosis
- [ ] Parasites
- [ ] Pneumonia
- [ ] Sexually Transmitted Infection
- [ ] Skin Disorder
- [ ] Stomach Ulcer
- [ ] Stroke
- [ ] Substance Abuse
- [ ] Thyroid Disorder
- [ ] Tuberculosis
- [ ] Ulcerative Colitis
- [ ] Other: ____________

Medications

What medications are you currently taking? (Include aspirin, blood thinners, vitamins, minerals, herbals, supplements, laxatives)

Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

- [ ] ACE Inhibitors
- [ ] Adhesive Tape
- [ ] Anesthetics
- [ ] Aspirin
- [ ] Codeine
- [ ] Fentanyl
- [ ] Iodine (including contrast dye)
- [ ] Latex
- [ ] Midazolam (Versed)
- [ ] NSAIDs (Ibuprofen, Naprosyn, Advil)
- [ ] Penicillin
- [ ] Seizure Medicines
- [ ] Sulfa
- [ ] Valium

Reactions: ____________

Family History

Has anyone in your family ever had any of the following conditions?

- [ ] Alcoholism
- [ ] Anxiety
- [ ] Cancer
- [ ] Celiac Disease
- [ ] Colon Polyps
- [ ] Crohn's Disease/Ulcerative Colitis
- [ ] Depression
- [ ] Diabetes
- [ ] Gall Bladder Disease
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Joint Disease
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Lung Disease
- [ ] Osteoporosis
- [ ] Rheumatism
- [ ] Thyroid Disorder
- [ ] None of the Above
- [ ] Not Sure

Details: ____________

Women Only

Number of Pregnancies: ____________

Number of Miscarriages: ____________

Number of Abortions: ____________

Number of Living Children: ____________

Check if you have had any of the following:

- [ ] Endometriosis
- [ ] Ovarian Cyst(s)
- [ ] Menopause
- [ ] C/Section
- [ ] Tubal Ligation

Birth Control: [ ] Yes [ ] No If yes, type: ____________

Hospitalizations & Surgeries

Reason	Date
Reason	Date
Reason	Date
Reason	Date