Park Hill Family Practice
7548 W. Sahara Ave. Ste#101
Las Vegas, NV 89117
(702) 871-3730

Patient Registration Form

Patient Information

Last Name:______________________ First Name:______________________ MI________
Mailing Address:______________________ City/State/Zip:______________________
Physical Address:______________________ City/State/Zip:______________________
Primary Phone:______________________ Type: Home/Cell/Work **Message ok?** Y or N
Alternate Phone:______________________ Type: Home/Cell/Work **Message ok?** Y or N
Email:______________________ Used for **Doctor Contact** Y or N **Newsletter** Y or N
Social Security Number:______________________ Date of Birth:______________________ Male/Female
Marital Status: S M D W O
Employer:______________________ Occupation:______________________

Responsible Party Information (Parent information if patient is a Minor)

Name:______________________
Address:______________________ City/State/Zip:______________________
Primary Phone:______________________ Alternate Phone:______________________

Insurance Information

*Primary Insurance Company Name:______________________
*Patients Relationship to Insurance Subscriber: Self/Spouse/Child/Other
*Name of Subscriber:______________________ *Date of Birth:______________________
*Social Security Number:______________________ Male/Female
*Insurance ID#:______________________ Group#:______________________ Effective Date:__________

*Secondary Insurance Company Name:______________________
*Patients Relationship to Insurance Subscriber: Self/Spouse/Child/Other
*Name of Insured:______________________ *Date of Birth:______________________
*Social Security Number:______________________ Male/Female
*Insurance ID#:______________________ Group#:______________________ Effective Date:__________

Emergency Contact Information

Name:______________________ Relationship:______________________
Primary Phone:______________________ Alternate Phone:______________________

I certify that the above is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Responsible Party Signature: ______________________

Responsible Party's Relationship to Patient: ______________________

Today's Date: ______________________

Family Medical History

	Age	Good Health	Poor Health	Deceased
Father				
Mother				
Brother (s)				
Sister (s)				
Grandparents (s)				

Medical History

Date of last visit____________________ Have you had any serious illnesses or operations? □ Y □ N

If yes describe____

Are you currently under physician care? □ Y □ N If yes describe____

Have you ever had a blood transfusion? □ Y □ N If yes, give approximate dates____________________

Woman: Are you pregnant? □ Y □ N Nursing □ Y □ N Taking birth control pills? □ Y □ N

Check ( ) if you had any of the following:

- □ AIDS / HIV Positive
- □ Alcohol / Drug Abuse
- □ Anaphylaxis
- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial heart valves
- □ Artificial joints
- □ Asthma
- □ Atopic (allergy prone)
- □ Back Problems
- □ Blood Disease
- □ Cancer
- □ Chemical Dependency
- □ Cholesterol problems
- □ Chemotherapy
- □ Circulatory problems
- □ Cortisone treatments
- □ Cough, persistent
- □ Cough up blood
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Food allergies
- □ Glaucoma
- □ Headaches
- □ Heart murmur
- □ Heart problems Describe__________
- □ Hemophilia / Abnormal Bleeding
- □ Hereditary Problems
- □ Herpes
- □ Hepatitis
- □ High blood pressure
- □ Jaw pain
- □ Kidney disease or malfunction
- □ Liver disease
- □ Material allergies (latex wool,metal,chemicals)
- □ Mitral valve prolapse
- □ Mother used alcohol, smoked or used recreational drugs During pregnancy
- □ Nervous problems
- □ Pacemaker / Heart surgery
- □ Psychiatric care
- □ Rapid weight gain or loss
- □ Radiation treatment
- □ Respiratory disease
- □ Rheumatic / Scarlet fever
- □ Seizures
- □ Shingles
- □ Shortness of breath
- □ Skin rash
- □ Spina Bifida
- □ Stomach / Intestinal problems
- □ Stroke
- □ Surgical Implant
- □ Swelling of feet / ankles
- □ Thyroid disease or malfunction
- □ Tobacco habit
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcer / Colitis
- □ Venereal disease

List medications you are currently taking if any:

____

____

List drug allergies, if any:

____

____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor or medical group all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all submissions.
I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature____ Date____________________

Payment is due in full at the time of treatment unless prior arrangement unless prior arrangements have been made.