ELGIN FAMILY PHYSICIANS ADULT (Ages 18 and over) REGISTRATION FORM TODAY'S DATE:_____

Welcome to Elgin Family Physicians. Thank You for completing the entire Patient Registration Form.

REGISTRATION DATA PLEASE PRINT

Date of Birth ____/_____/_____Gender: ☐ Male ☐ Female Marital Status: _____ Religion: _____

Last Name: _____ First Name:_____ MI:_____

Address:_____

SSN: _____Employer:_____

Phones: Home_____ Work: _____Ext:_____ Cell_____

Which Phone is Your Best Contact Number? ☐ Home ☐ Work ☐ Cell Can we leave a detailed message at this Number? ☐ Yes ☐ No

Email Address:_____ Do you wish to use the patient portal? ☐ Yes ☐ No

Race: _____ Ethnicity: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Emergency Contact: _____ Relationship to You: _____

Phones: Home_____ Work: _____Ext:_____ Cell_____

Which Phone is Their Best Contact Number? ☐ Home ☐ Work ☐ Cell Can we leave a detailed message at this Number? ☐ Yes ☐ No

Referred by/How Did You Hear About Us:

_____

Medical insurance Information:	**Insurance Company**	**Policy Number**	**Policy Holder**	**DOB**
Primary:	_____	_____	_____	_____
Secondary:	_____	_____	_____	_____

Person to Receive Bills: ☐ Self ☐ Other _____ Relationship to You: _____

Address if Different than Yours: _____

Their Phones: Home_____ Work: _____Ext:_____ Cell_____

Which Phone is Their Best Contact Number? ☐ Home ☐ Work ☐ Cell

MEDICAL HISTORY

MEDICATIONS: List all Medications you take, include over the counter medications and Vitamins/supplements(Attach Separate List if Necessary):

Medication	Dosage	Frequency	Medication	Dosage	Frequency
_____			_____		
_____			_____		
_____			_____		
_____			_____		

ALLERGIES: List all medications to which you are allergic including food and seasonal allergies:

_____ _____ _____ _____ _____

HABITS: Do You Smoke? ☐ Never Smoked ☐ Former Smoker? How Long Ago Did You Quit? _____

☐ Current Smoker? How Many Packs Per Day? _____ Interested in Quitting? ☐ Yes ☐ No

Do You Drink? ☐ Yes ☐ No If Yes How Many Ounces per day? _____ How Many Times Per Month? _____

Have you ever taken Recreational Drugs? ☐ Yes ☐ No If yes: What?_____ When? _____

HOSPITALIZATIONS: List all hospitalizations, injuries and operations (Attach Separate List if Necessary):

Year	**Illness, Injury or Operation**	**Hospital**	**City & State**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL HEALTH HISTORY: Check all the items below that apply to you

☐ Alcoholism	☐ Anemia	☐ Asthma	☐ Auto Immune Disease	☐ Bladder Issues
☐ Cancer Type_____	☐ Diabetes	☐ Depression	☐ Drug Abuse	☐ High Blood Pressure
☐ Epilepsy	☐ Glaucoma	☐ Hepatitis	☐ Heart Disease	☐ Kidney Disease
☐ Liver Disease	☐ Obesity	☐ Osteoarthritis	☐ Lung Disease	☐ Mental Illness
☐ Phlebitis	☐ Ulcer	☐ Rheumatic Fever	☐ Stroke	☐ Rheumatologic Condition
☐ Suicide Attempt	☐ Thyroid Disease	☐ Uncontrolled Bleeding	☐ Sexually Transmitted Diseases	

☐ Other: _____

PLEASE COMPLETE THE REVERSE SIDE

PREGNANCY HISTORY: **Enter the number of**

Pregnancies_____ Live Births _____ Abortions_____ Premature Births_____ Miscarriages____ Living Children_____

IMMUNIZATION HISTORY: **Indicate those that you have received including month and year received**

Pneumonia: _____ Flu: _____ Tetanus: _____ Zostervax: _____

Rubella: _____ Other: _____ Other: _____ Other: _____

FAMILY HEALTH HISTORY

	First Name	Year of Birth	Health is: Good	Poor	Died at Age	Cause of Death	Current Medical Problems
Father	_____	_____	☐	☐	_____	_____	_____
Mother	_____	_____	☐	☐	_____	_____	_____
Spouse	_____	_____	☐	☐	_____	_____	_____
Children	_____	_____	☐	☐	_____	_____	_____
	_____	_____	☐	☐	_____	_____	_____
	_____	_____	☐	☐	_____	_____	_____
	_____	_____	☐	☐	_____	_____	_____
Father's Father		_____	☐	☐	_____	_____	_____
Father's Mother		_____	☐	☐	_____	_____	_____
Mother's Father		_____	☐	☐	_____	_____	_____
Mother's Mother		_____	☐	☐	_____	_____	_____

Number of Brothers? _____Number Living? _____Number Deceased? _____ Causes of Death? _____

List any Medical Problems of Brothers: _____

Number of Sisters? _____Number Living? _____Number Deceased? _____ Causes of Death? _____

List any Medical Problems of Sisters: _____

FAMILY HEALTH HISTORY: **Check all the items below that apply to your family**

☐ Alcoholism	☐ Anemia	☐ Asthma	☐ Auto Immune Disease	☐ Bladder Issues
☐ Cancer Type_____	☐ Diabetes	☐ Depression	☐ Drug Abuse	☐ High Blood Pressure
☐ Epilepsy	☐ Glaucoma	☐ Hepatitis	☐ Heart Disease	☐ Kidney Disease
☐ Liver Disease	☐ Obesity	☐ Osteoarthritis	☐ Lung Disease	☐ Mental Illness
☐ Phlebitis	☐ Ulcer	☐ Rheumatic Fever	☐ Stroke	☐ Rheumatologic Issue
☐ Suicide Attempt	☐ Thyroid Disease	☐ Uncontrolled Bleeding		

☐ Other: _____

PERSONAL WORK HISTORY

Are you working now? ☐ Yes ☐ No ☐ Retired ☐ Never Worked ☐ In Between Jobs ☐ Student

Starting with your most recent job what type of work have you done? **Work Exposure Check all that apply**

Type of Work	From	To				
_____	_____	_____	☐ Fumes	☐ Dust	☐ Coal	☐ Lead
			☐ Stress	☐ Asbestos	☐ Solvents	☐ Heavy Lifting
_____	_____	_____	☐ Degreasers	☐ Halothane	☐ Loud Noises	☐ Salicylates
_____	_____	_____	☐ Physical Strain	☐ Heavy Lifting	☐ Pesticides	☐ Mercury
_____	_____	_____	☐ Pressure	☐ Other: _____		

HEALTH CARE PROVIDERS INCLUDING SPECIALISTS: **Who have you seen for your health care needs in the past five Years?**

Name of Doctor or other Providers **Primary Problems Cared For**

_____

_____

_____

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: **I authorize the release of any medical records or medical and financial information necessary to process any medical claims for services provided to the above named patient. In addition, I authorize payment of medical benefits to Elgin Family Physicians, SC for medical services. I understand that my insurance may not cover all the costs for medical services provided by Elgin Family Physicians. As such, I agree to assume full financial responsibility for any portions not covered.**

SIGNED _____ Date _____