REGISTRATION and HISTORY RECORD

REGISTRATION DATA

Name:	**Sex:**
Address:	**Martial Status:**
	Employed by:
Home Phone:	
Soc. Sec. No:	**Drivers Lic. No:**

IN CASE OF EMERGENCY INFORMATION

Name:	**Relationship to you:**
Home Phone:	**Work Phone:**

MEDICAL INSURANCE INFORMATION (We will need to copy your insurance card(s) each visit)

Person to receive bills:	**Relationship to you:**
Address:	**Their Home Phone:**
	Their Work Phone:
Their Soc. Sec. No:	**Date of Birth:**

DECLARATION (To be signed after form is printed)

I, the undersigned, have insurance coverage with and assign directly to Primary Care Group all Surgical and/or medical benefits for services rendered. I understand that I am financially responsible for all charges wherther or not paid by insureance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: **Signature:** _____

MEDICARE PATIENTS ONLY: PLEASE SIGN AFTER PRINTING FOR LIFETIME AUTHORIZATION

I authorize Primary Care Group to release to the Health Care Financing Administration and Social Security Administration or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insureance benefits to Primary Care Group or the party who accepts assignment.

Date: **Signature:** _____

FAMILY HEALTH RECORD	Health is: (G)ood (P)oor (	Age	Cause of Death
Father's First Name:			
Mother's First Name:			
Brothers & Sisters:			
Spouse's First Name:			
Children's First Names:			

ILLNESSES: Answer 'X' for you or 'F' for members of your family have had the following illnesses or problems

Alcoholism:	Depression/anxiety:	Low back pain:
Anemia:	Epilepsy:	Lung Disease/TB:
Arthritis:	Glaucoma:	Stroke:
Asthma:	Headache:	Suicide attempt:
Blood Clots:	Heart Disease:	Thyroid Diease:
Cancer, Tumor:	Hear murmur:	Uncontrolled bleeding:
Colitis/Stomach:	High blood pressure:	Other:
Diabetes:	Kidney/bladder:	
Drug abuse:	Liver disease/Hepatitis:	

HABITS:	(Y)es OR (N)o	DRUGS and/or OTHER ALLERGIES
Caffeine:		1
Smoking:		2
If yes-how many packs daily:		3
Drugs:		4
Alcohol:		5
If yes-how much daily:		6

	Health Care Provider	Name of Hospital	Primary Problem	City and State	Year
1					
2					
3					
4					
5					
6					
7					
8					
9					