



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

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

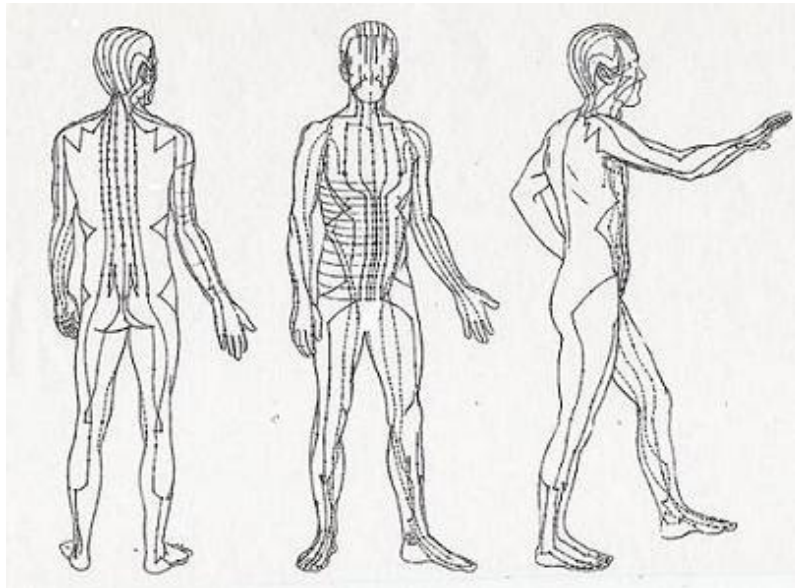
Gynecological	
	Still Having Periods
	# of Pregnancies _____
	# of Deliveries _____
	Last Gyn Exam Date: _____
	Last Mammogram Date: _____
	Hormone Therapy

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: _____