Troy Arthritis Care Patient Registration and Office Policy

Name_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell # _____ Work # _____

Sex _____Male _____ Female

Primary Pharmacy_____ Phone # _____

Secondary Pharmacy_____ Phone # _____

Race

____White ____Native Hawaiian/Pacific Islander ____Asian ____Other

____Black/African American ____American Indian/Alaskan Native ____Patient Declined

Ethnicity

____Spanish/Hispanic origin ____Not Spanish/Hispanic origin _____Patient declined ____Unknown

Language

_____English _____Spanish _____Other

HIPPA Privacy Information

How may we contact you regarding **appointment** information?

___Home Phone ____Cell Phone ____Office Voice mail ___Send Via Mail/answering machine

With another person? Name(s)_____

How may we contact you regarding **medical** Information?

___Home Phone ____Cell Phone ____Office Voice mail ___Send Via Mail/answering machine

With another person? Name(s)_____

Initial in the spaces provided and sign at the bottom.

_____MEDICATION LIST

I understand I am responsible to provide the office of Robert Z. Dadekian, M.D. with an UPDATED and ACCURATE medication list at each office visit. This list should include the medication names, dosages and how often I take them. I understand supplements should be included as well. This list will be scanned into my permanent medical record.

_____NO SHOW/LATE CANCELLATION

You will be billed $25 for any appointment you do not keep or for late cancellations. (Less than 24 hours notice.)

_____COPAYMENT NON-COMPLIANCE

You will be billed $5 if you do not make your copayment, coinsurance or regular payment at the time of service.

_____ PRIVACY PRACTICES

I acknowledge that I was provided with the Notice of Privacy Practices for Troy Arthritis Care.

I have read the Office Policies of Troy Arthritis Care and agree to them in full and without condition.

_____ _____

Patient/Guardian Date

_____ _____ Signature

Date

List all **medical problems**. (i.e. high blood pressure, diabetes, angina, ulcers etc.)

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

List any **surgeries** and year you have had.(i.e. tonsils, appendix, cataracts, prostate, gallbladder, colonoscopy etc.

EX. Colonoscopy 2001

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

List **allergies** and side **effects**.

ALLERGY	Side effect
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

List **medications**, doses and number of times taken per day, week or month.

Medication	**MG, Units,mcg**	**Taken**
Ex. Motrin	800mg	1 tab 3 times daily

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

FAMILY HISTORY

	Alive/Age	**Deceased/Age**	**Health**
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(1)	_____	_____	_____
Brother (2)	_____	_____	_____
Sister (1)	_____	_____	_____
Sister (2)	_____	_____	_____
Child(1) M/F	_____	_____	_____
Child (2) M/F	_____	_____	_____
Child (3) M/F	_____	_____	_____

Social History

Please “x”:

_____Married _____Single _____Divorced _____Widow

List your Occupation_____ Retired? _____

Do you or have you ever smoked? Yes No

If yes, please “x”:

_____Current Smoker _____Former Smoker _____Never Smoked

Cigarettes Cigars If other, please list:_____

Do you drink alcohol? Yes No

If yes, please circle and list how often and type.

_____Rarely _____Occasionally _____Number per day _____Number per week

Type of alcohol_____

Sign Date