Ashcake Family Physicians

Patient Registration

Please present your insurance card(s) and picture ID to the receptionist

Personal information: **(please print)**

Circle: Miss Mrs. Ms. Mr. Dr. Social Security #: ____________________

Name: ____
Last First M.I

____
Address City State Zip Code

Telephone #: Home:______________ Work: ______________ Cell: ______________

Date of Birth: ____________________ Gender: _____ Male _____ Female

Employer : ____________________

Work Address: ____________________

____

Occupation: ____________________

How long have you worked there? __________

Spouse's Name:____________________

Spouse's Employer: ____________________

Spouse's work Telephone: ____________________

In Case of Emergency, Notify:

Name: ____________________

Address: ____________________

____

Telephone #: ____________________

Relationship to Patient: ____________________

Primary Insurance Information:

Insurance Co: ____________________

Policy Holder: ____________________

Relationship to policy holder: ____________________

Policy #: ____________________

Group #: ____________________

Account Guarantor (financially responsible):

Name: ____________________

Social Security #: ____________________

Address: ____________________

____

Telephone #: ____________________

Relationship to Patient: ____________________

Secondary Insurance Information:

Insurance Co: ____________________________ Policy #: _________________________________

Policy Holder: ____________________________ Group #: _________________________________

Relationship to policy holder: ________________

Ashcake Family Physicians
Patient History Questionnaire

Name: _______________________________ Date: ___________________

Past Medical History/ Chronic Illnesses:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Past Surgeries (surgery/date):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Medications (name/strength/dosage):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Allergies (cause/symptoms):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Social history:

__ Single __ Married __ Divorced __Widowed

Spouse's Name: ______________________________

Children? _____ How Many? ______

Occupation: ____________________

Do you smoke? _______ if yes, how many packs per day ____/ ____years

Do you drink alcohol? ________ if yes, how many drinks _______ day/week/month

Do you use illicit drugs? _______ if yes, which drugs and how often:____

Family History: Who in your family has been diagnosed with the following diseases?

High blood pressure: _____________________

Diabetes: _____________________________

Heart attack: ___________________________

Stroke: _______________________________

Blood clots: ____________________________

Asthma: ______________________________

Cancer (what kind): ______________________