

Homer Medical Clinic

4136 BARTLETT HOMER, AK 99603-7015 PH 907.235.8586 FAX 907.235.6639

PATIENT REGISTRATION
Patient Personal Information

Name (First, MI, Last), Mailing Address, Physical Address, City/ST/Zip, Social Security Number, Marital Status, Date of Birth, Phone, Email Address, Occupation, Employer, Referred by

Insurance Information

Insurance Carrier, Insurance I.D.#, Group#, Subscriber's Name, Subscriber's Date of Birth

Secondary Insurance Information

Insurance Carrier, Insurance I.D.#, Group#, Subscriber's Name, Subscriber's Date of Birth

Spouse Parent Information

(Complete only if spouse or parent is not the responsible party) Name, Address, Email Address, City/ST/Zip, Date of Birth, Phone, Relationship checkboxes

Pediatric Patient Registration

(to register all family members with one form)

Child's name, Date of Birth, Circle gender (F, M) for multiple children

Children Live With checkboxes: Mother, Father, Both, Other, Step-Father, Step-Mother

Responsible Party Information

Name, Address, City/ST/Zip, Date of Birth, Circle gender (F, M), Social Security Number, Phone, Relationship to Patient checkboxes

Emergency Contact

Name, Phone (Home/Work/Cell), Relationship checkboxes: Husband, Step-Mother, Wife, Step-Father, Father, Legal Guardian, Mother, Friend

Signature of Patient or Representative

Today's Date

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**HEALTH ASSESSMENT QUESTIONNAIRE**

Today's date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date of birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name \_\_\_\_\_

Occupation \_\_\_\_\_

**Allergies to Medication** (indicate reaction, i.e. rash, vomiting, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

**Past Medical Problems** (operations, illnesses, injuries)

Year	Problem	Hospital

**Family History**

Relationship	Age if living	Age at Death	State of Health or Cause of Death
Father			
Mother			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Child:			
Child:			
Child:			
Child:			
Child:			

**Present or Recurrent Medical Problems**

Year	Problem	

**Medications** (indicate dose and frequency)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_

Illness	Family member with Illness	Age at Onset
Breast Cancer		
Colon Cancer		
Prostate Cancer		
High Blood Pressure		
Coronary Artery Disease		
Diabetes		

(Please complete the backside of this form)

