PATIENT REGISTRATION

Welcome to Sierra Madre Community Medical Group

Full Name (Last, First, Middle): ____

Date of Birth: _______ Sex: ________ Preferred Pronouns (circle one): He/Him She/Her They/their

Title (circle one): Mr. Mrs. Miss. Dr.

Marital Status (circle one): Single Married Divorced Separated Widowed

Address: ____ Apt #:___________________

City/State/Zip: ____

Email Address: _______________________________ Occupation: _________________________

Home Telephone: _____________________________ Employer: ___________________________

Cellular Phone: _______________________________

Emergency Contacts

Name: ______________________ Relationship to Patient: ___________ Tel: (____) ______________

Name: ______________________ Relationship to Patient: ___________ Tel: (____) ______________

Driver License #: ________________________

How Were You Referred to Sierra Madre Community Medical Group?

____

- If you would like to give authorization to share your protected health information or allow somebody to pick up your prescriptions or laboratory slips, please ask the receptionist for the form titled "AUTHORIZATION OF RELEASE OF MEDICAL RECORD."
- If the patient is a minor, ask the receptionist for "AUTHORIZATION FOR SERVICES RENDERED TO A MINOR."
- The physicians of Sierra Madre Community Medical Group might order some laboratory tests that need to be performed for diagnostic and screening purposes. We are going to direct you to a laboratory contracted with your insurance. You are responsible to check if the tests ordered on the laboratory slip are covered by your insurance and if they apply toward your deductible.
- I hereby authorize the office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage.

____ ____________________________

Signature of Patient or Representative Date

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NEW PATIENT MEDICAL HISTORY FORM

ALLERGIES ☐ **No allergies**

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS (Please list ALL)	DOSE (Mg, mcg, pill, etc.)	TIMES PER DAY

If you need more room to list medications, please write on a separate sheet of paper

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	DATE:	Facility/Provider:	Abnormal Result? Y N
HEMOGLOBIN A1C	DATE:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY	DATE:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	DATE:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	DATE:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	DATE:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tdap:	Last Pneumonia Vaccine:
Last Flu Vaccine:	Last Zoster Vaccine (Shingles):
Last COVID Vaccine/Booster:	

Patient Name: ____ DOB: _______________________

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PERSONAL MEDICAL HISTORY

CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer (type: ______________________)			
Depression/Anxiety/Bipolar			
Diabetes (type: ____________________)			
COPD			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol (hyperlipidemia)			
Thyroid disease/Hypothyroidism			
Kidney (renal) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE (specify left/right)	**DATE**	**LOCATION/FACILITY**

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: ____ Age of Menopause: ______
Total Number of Pregnancies:	Number of Live Births:

Patient Name: ____ DOB: ______________________

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FAMILY MEDICAL HISTORY ☐ **No significant family history is known**

	Alcohol/Drugs Abuse	Asthma	Cancer (type:)	Depression/Anxiety/Bipolar	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:
Mother														
Father														
Brother														
Sister														
Child														
Maternal Grandmother														
Maternal Grandfather														
Paternal Grandmother														
Paternal Grandfather														
Other: ___________														

Patient Name: ____ DOB: _________________________

SOCIAL HISTORY

Occupation:	Employer:
Years of Education or Highest Degree:	
Do you have children? Y N	If yes, how many?

TOBACCO USE		Smoker Cigarettes? Y N (If you never smoked, please move to Alcohol/Drug Use)	
Current: Packs/day _____ # of Years _____		Past: Quit Date _________ Packs/day ______ # of Years _____	
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	Circle one: Beer Wine Liquor	# of Drinks/week:
Do you use recreational drugs: Y N		Have you ever used needles to inject drugs? Y N	

EXERCISE	What kind of exercise? ________________________ Duration: _________ How often: ________
SLEEP	How many hours, on average, do you sleep at night?
DIET	How would you rate your diet? Good Fair Poor

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiologist		
Gastroenterology (GI)		
OB/GYN		
Neurology		
Pulmonology		
Rheumatology		
Other: _____________________		
Other: _____________________		

Patient Name: ____ DOB: ______________________