ASANTE
Physician Partners

First Time Patient? Today's Date: _____ Time In: _____

PLEASE PRINT **REGISTRATION FORM** **COMPLETE ALL BOXES**

Patient Information

Name: _____ SSN: _____ Gender: M F
Date of Birth: _____ Previous Name: _____
City of Birth _____ Country of Origin _____
Street Address: _____ **P.O. Box** _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone _____
Language: _____ Need Interpreter: ☐ Yes ☐ No Marital Status: _____ Religion: _____
Race: _____ Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐ No Response
Primary Care Provider/Family Doctor: _____ Email Address: _____
Is legal counsel involved in your care? ☐ Yes ☐ No

Responsible Party

☐ Same as Patient

Responsible Party: _____ SSN: _____
Address: _____ Phone: _____ Relationship to Patient: _____
Employer: _____ Work Address: _____ Work Phone: _____

Patient Contacts

Name: _____ Relationship to Patient: _____ Phone: _____
Address: _____
Name: _____ Relationship to Patient: _____ Phone: _____
(Not Living with Patient)

Employer Information

Patient Employer: _____ Employer Address: _____
Employment Status: ☐ Full Time ☐ Part Time ☐ Student Employer Phone: _____

Health Insurance Information

Primary Insurance: _____ Member ID: _____ Group #: _____

Effective Date: _____ Subscriber Name: _____ SSN: _____
DOB: _____ Subscriber Address: _____ Subscriber's Employer: _____
Number of Employees: ☐ 1-19 ☐ 20-99 ☐ 100+ Phone: _____ Relation to Patient: _____
Secondary Insurance: _____ (If applicable) Member ID: _____ Group #: _____
Effective Date: _____ Subscriber Name: _____ SSN: _____
DOB: _____ Subscriber Address: _____ Subscriber's Employer: _____
Number of Employees: ☐ 1-19 ☐ 20-99 ☐ 100+ Phone: _____ Relation to Patient: _____

For Work Related Injuries

Date of Injury: _____ Injury/Accident Insurance Carrier: _____ Claim/Auth #: _____

How did you hear about our clinic?

☐ Referral from your primary care physician ☐ Word of Mouth ☐ Postcard mailed to your home
☐ Website ☐ Newspaper Article ☐ Newspaper Advertisement ☐ Radio Advertisement ☐ Yellow Pages
May we contact you via email regarding special promotions or to request information about our services? ☐ Yes ☐ No

ASANTE®
Physician Partners

Date: _____

PATIENT: _____ **DOB:** ____/____/____

ALLERGIES *Reaction*

Aspirin	
Codeine	
Morphine	
Other Allergies	
Sulfas	
Tetanus	
Dyes	
Penicillin	
Other	

CURRENT MEDICATIONS
(Including vitamins, herbs, diet pills, OTC, etc.)

Drug Name	Strength	Dosage

PAST MEDICAL HISTORY – Please check if you have experienced any of the following problems and indicate date of onset:

	Date of Onset		Date of Onset		Date of Onset
☐	Alcoholism	☐	Diabetes mellitus	☐	Leukemia
☐	Anemia	☐	Dermatitis	☐	Liver Disease
☐	Arthritis	☐	Emphysema	☐	Meningitis
☐	Anxiety	☐	GERD	☐	Myocardial infarction
☐	Arrhythmia	☐	Glaucoma	☐	Nerve/muscle disease
☐	Asthma	☐	Heart Disease	☐	Osteoporosis
☐	Blood Dyscrasia	☐	Heart Murmur	☐	Pneumonia
☐	Blood Transfusion	☐	Hepatitis	☐	Psychiatric Problem
☐	Bronchitis	☐	Herpes	☐	Rheumatic Fever
☐	Cancer	☐	HIV/AIDS	☐	Seizures
☐	CHF	☐	Hypertension	☐	Sickle cell anemia
☐	Clotting disorder	☐	Inflammatory bowel disease	☐	STD
☐	Concussion	☐	Jaundice	☐	Thyroid disease
☐	COPD	☐	Kidney Disease	☐	Tuberculosis
☐	Chronic Lung Disease	☐	Kidney Stones	☐	Ulcers
				☐	Varicosities/Phlebitis

☐ Other Serious Illnesses or Injuries: _____

SURGERIES/HOSPITALIZATIONS – Please check if you have had surgery or hospitalization for the following:

	Year		Year		Year
☐	Appendectomy	☐	Cosmetic surgery	☐	Prostate surgery
☐	Brain surgery	☐	Eye surgery	☐	Small intestine surgery
☐	CABG	☐	Fracture surgery	☐	Spine surgery
☐	Cholecystectomy	☐	Hernia repair	☐	Valve replacement
☐	Colon surgery	☐	Joint replacement	☐	Vasectomy
☐	C-Section	☐	Hysterectomy	☐	Tonsillectomy

☐ Other _____

PATIENT : _____ **DOB:** ____ / ____ / ____ **DATE:** _____

FAMILY HISTORY – Please check if your family members (parents, grandparents, siblings, children, aunts, uncles) have had any of the following:

	Diagnosis	Relationship(s)	Living		Diagnosis	Relationship(s)	Living
☐	Alcohol Abuse		Y/N	☐	Heart Disease		Y/N
☐	Arthritis		Y/N	☐	High cholesterol		Y/N
☐	Asthma		Y/N	☐	Hypertension		Y/N
☐	Birth Defect		Y/N	☐	Kidney Disease		Y/N
☐	Cancer		Y/N	☐	Learning Disability		Y/N
☐	COPD		Y/N	☐	Mental Illness		Y/N
☐	Depression		Y/N	☐	Mental Retardation		Y/N
☐	Diabetes		Y/N	☐	Miscarriage/Stillbirth		Y/N
☐	Drug Abuse		Y/N	☐	Stroke		Y/N
☐	Early Death		Y/N	☐	Vision Loss		Y/N
☐	Hearing Loss		Y/N		Other:		Y/N
☐	Other:						Y/N

SOCIAL HISTORY

Alcohol Use: ☐ YES ☐ NO

per week: _____ glasses of wine _____ cans of beer _____ Shots of liquor ____ Drinks containing 0.5 oz of alcohol

Sexually Active? ☐ YES ☐ NO Partners: ☐ FEMALE ☐ MALE

Birth Control/Protection :___ Abstinence ___ Coitus interruptus ___Condom ___ Diaphragm ___Implant ___Inject ___Inserts ___IUD ___OCP ___Patch ___Post-menopausal ___Rhythm ____Spermicide ___Sponge ___Surgical Other: _____ ___None

Drug Use – ☐ YES ☐ NO Type: Use/week:

Tobacco Use – Do you smoke now ☐ YES ☐ NO Packs/day __0.25 __0.5 __1 __1.5 __2 __3

Years __ 0.5 __1 __2 __3 __4 __5 __10 __15 Quit Date:_____

Smokeless Tobacco: _____ Quit Date: _____

Ready to Quit: ___Yes ___No Counseling Given: ___Yes ___No

Do you consume caffeine? ☐ YES ☐ NO

Do you exercise? ☐ YES ☐ NO What type? _____ How often?_____ Times/week

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Spouse Name: _____ Number of Children _____ Yrs of Education _____

Occupation: _____

HEALTH MAINTENANCE

Colonoscopy:	☐ YES	☐ NO	Year: _____	Influenza Immunization:	☐ YES	☐ NO	Year: _____
Dexa (Bone) Scan	☐ YES	☐ NO	Year: _____	Pneumonia Vaccine:	☐ YES	☐ NO	Year: _____
PSA Screening:	☐ YES	☐ NO	Year: _____	Tetanus Vaccine:	☐ YES	☐ NO	Year: _____
Mammography:	☐ YES	☐ NO	Year: _____				

WOMAN'S HEALTH

		Pregnancies	Total	Pregnancies	Total
Age Periods Started	_____	Full-Term	_____	# of Children Living	_____
Age at 1st Birth	_____	Pre-Term (37 wks)	_____	Ectopic or Tubal	_____
Age/Year Menopause	_____	Miscarriages	_____	Live Births Cesarean	_____
Last Pap Smear	_____	Elective Abortions	_____	Live Births Vaginal	_____

PATIENT : _____ **DOB:** ____ / ____ / ____ **DATE:** _____

Please CIRCLE any of the following that you are **currently** experiencing

Eyes:
Blurred Vision
Seeing Double
Seeing Halos
Eye Pain
Watering
Itching
Wear Glasses/Contacts
Date of Last Exam: _____

Ears:
Difficulty Hearing
Buzzing or Ringing
Frequent Earaches/Infections
Motion Sickness
Drainage
Use Hearing Aid(s)

Mouth:
Dental/Gum Problems
Frequent Sores
Swelling or Lumps
Wears Dentures

Nose & Throat:
Frequent Nosebleeds
Sinus Problems
Nasal Congestion
Frequent Sore Throats
Hoarse Voice
Snoring

Skin:
Rashes
Sores
Change in Mole
Lumps or Swelling
Bleed or Bruise Easily
Itching

Nervous Systems:
Seizures
Numbness/Tingling
Trembling/Shaking
Fainting Spells
Change in Handwriting
Speech Difficulty
Loss of Muscle Strength

Musculoskeletal:
Aching Muscles/Joints
Swollen Joints
Weakness
Tingling
Handicapped
Fractures

Endocrine:
Weight Changes
Always Hungry
Tendency to Feel Hot or Cold
Dryness of Skin or Hair
Change in skin pigmentation

Cardiovascular:
Chest Pains
Dizziness
Racing Heart
Shortness of Breath
Swollen Feet or Ankles
Leg Cramps
Irregular Heartbeat
Poor Circulation

Respiratory:
Wheezing
Frequent Cough
Cough up Phlegm
Cough up Blood
Excessive Sweating
Sit up to Sleep
Trouble Breathing

Digestive:
Frequent Indigestion
Heartburn
Frequent Belching
Bloated Stomach
Loss of Appetite
Nausea or Vomiting
Spit up Blood
Constipation
Diarrhea
Black/Grey/Bloody Stools
Rectal Pain
Rectal Bleeding
Change in Stools

Urinary:
Frequent Urination
Burning or Pain
Trouble Starting
Bedwetting
Dribbling/Incontinence
Brown/Black/Bloody Urine

Head & Neck:
Frequent Headaches
Migraines
Neck Pains
Lumps or Swelling
Difficulty Swallowing

General:
Always Tired
Trouble Sleeping
Often Crying
Depressed
Hopeless Outlook
Considered Suicide
Lose Temper Often
Trouble Relaxing
Anxiety
Work/Family Problems
Change in Memory/Concentration
Sexual Difficulty/Problems

Male Genital:
Night Time Urination
Abnormal Lumps in Scrotum
Painful Testicles
Impotence
Burning/Discharge
Multiple Sexual Partners
Type of Contraception: _____

Female Genital:
Irregular Periods
Abnormal Bleeding
Vaginal Discharge
Severe Cramps
Hot Flashes
Hormones-Menopause
Post-Menopausal Bleeding
Lumps in Breasts
Perform Self Breast
Had Hysterectomy

Miscellaneous:
_____
_____