Integrated Medical Services (IMS)
New Patient Registration Sheet

Personal Information

Today's Date: ___________________

Patient First Name: _________________________ Initial: _______ Last Name: ____

DOB: _______________ Age: ________ Social Security #: ________________________ Email: ____________________________

Address: ____
Street Apt # City/State/Zip

Home Phone: _________________________ Work Phone: _________________________ Cell phone: ___________________________

Gender : M F Language: ENG SPAN OTHER: ___________________ Marital Status: S M W D O

Race/Ethnicity: ____ White ____ Black/African American ____ American Indian ____ Alaska Native ____ Asian

____ Native Hawaiian/Pacific Islander ____ Hispanic/Latino ____ Other______________________

Occupation: _______________________________ Retired: _____ YES _____ NO From: _______________________________

Employer Name: ____ Phone Number: _______________________________

Address: ____ City/State/Zip: ____

Financial Responsible Party Information

Responsible Party Name: ____ Relationship to patient: _________________________

DOB: _____________________________ Age: _______________ Social Security #: ____________________________________

Emergency Contact Name: _______________________________________ Phone Number: ___________________________________

Relationship to patient: ___________________________

Insurance Information

Primary Insurance: _________________________________ Address: ____

Policy #: ____ Group #: ____

Policy Holder Name: ________________________________ DOB: ___________________ Relationship to patient: _____________

Secondary Insurance: _______________________________ Address: ____

Policy #: ____ Group #: ____

Policy Holder Name: ________________________________ DOB: ___________________ Relationship to patient: _____________

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Release of Information

The person listed below has my consent to receive medical information, concerning the above patient, in person or over the phone. They will also be able to pick up any necessary prescriptions (other than controlled substances), x-rays and lab slips.

Name: ______________________________ Relationship to patient: ________________ Phone Number: ______________________

AUTHORIZATION TO BILL/PAY: I HEREBY AUTHORIZE IMS AND ITS AFFILIATES TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT WHICH COULD INCLUDE HIV, COMMUNICABLE DISEASE, OR DRUG ABUSE INFORMATION. I ALSO HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BUSINESS OFFICE OF IMS AND ITS AFFILIATES FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. ***I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE. FURTHER, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED IN THE COLLECTION OF MY ACCOUNT(S) AND WILL PAY ALL FEES INVOLVED SHOULD MY ACCOUNT(S) BE PLACED WITH A COLLECTION SERVICES.***

_______________________________ _______________________________ _______________________________

Patient/Guardian Signature Printed Name Date

Advanced Directives

Do you have a living will? _____ YES _____ NO Current copy provided: _____ YES _____ NO

Do you have a durable power of attorney for healthcare? _____ YES _____ NO Current copy provided: _____YES _____ NO

Are you an organ donor? _____ YES _____ NO Donor card/copy provided: _____ YES _____ NO

Health Maintenance and Promotion

AGE			Check all that apply
16-18	Counseling	Healthy lifestyle; tobacco use, sexual behavior, seat belts, alcohol use, dental care, substance abuse, guns	
	Tests	Urine, cholesterol and blood sugar once	
	Exam	Heart murmur, blood pressure, testicular exam	
18-30	Counseling	Healthy lifestyle; tobacco use, sexual behavior, seat belts, alcohol use, dental care, substance abuse, guns	
	Tests	Urine, cholesterol and blood sugar three times	
	Exam	Blood pressure and Pap smear every other year with one complete physical	
30-40	Counseling	Healthy lifestyle; tobacco use, sexual behavior, seat belts, alcohol use, dental care, substance abuse, guns, exercise, diet, tetanus vaccine	
	Tests	Initial mammogram. Cholesterol and HDL. Blood tests every three years	
	Exam	Initial breast exam, every other year Pap smear, two complete physicals	
40-50	Counseling	Healthy lifestyle; tobacco use, sexual behavior, seat belts, alcohol use, dental care, glaucoma screening, substance abuse, exercise, diet, tetanus	
	Tests	Initial PSA. Yearly mammograms, cholesterol and blood tests	
	Exam	Four complete physicals including prostate exam and Pap smear	
50-65	Counseling	Exercise, diet, tobacco use, sexual behavior, seat belts, alcohol use, dental care, glaucoma screening, menopause, substance abuse, tetanus	
	Tests	Yearly blood tests, mammograms and PSA. Colonoscopy every 3-5 years	
	Exam	Four complete physicals including a rectal exam, prostate exam, Pap smear	
65+	Counseling	Healthy lifestyle; tobacco use, seat belts, alcohol use, hearing screen, glaucoma screening, fall prevention, depression, excersise	
	Tests	Mammogram to 75. Colonoscopy every 3-5 years and blood tests yearly	
	Exam	End Pap smears, start yearly physical	
	Other	Influenza vaccine yearly, pneumonia vaccine once, tetanus	

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Reason for Visit

Primary reason for visit: ________________________ Date symptoms started: ________________________

Related to an Auto Accident? YES NO Work Related? YES NO Date of Injury: ________________

Were you seen at the Hospital/Urgent Care: YES NO If YES, where? ________________________

Other issues you would like to discuss: ____

Medical History

Current	Past	
		Anemia
		Arthritis
		Asthma
		Birth Defect
		Bladder/Urinary Problem
		Bleeding Disorder
		Broken Bones
		Cancer
		Chest Pain
		Colitis
		COPD
		Depression
		Diabetes
		Enphysema
		Epilepsy
		Fibromyalgia
		Goiter
		Headaches
		Hearing Impaired
		Heart Attack

Current	Past	
		Heart Disease
		Hepatitis
		Hernia
		HIV/AIDS
		Hypertension
		Irritable Bowel
		Kidney Disease
		Lupus
		Lyme Disease
		Prostate
		Seizures
		Skin Disorder
		Sleep Disorder
		Stomach Ulcer
		Stroke
		TB
		Thyroid Disease
		Valley Fever
		Vision Impairment
		Weight Loss/Gain

Immunizations & Screenings

Measles			OPV					
Mumps			DPT					
Rubella			HBV				HIB	
Pneumonia								
Influenza								
Td								
PAP/PSA								
Colon								
Mammo								

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Family Medical History

	Mother	Father	Grandparent	Sibling	Child
Alzheimer's					
Arthritis					
Asthma					
Bleeding Disorder					
Cancer					
COPD					
Depression					
Diabetes					
Epilepsy					
Genetic/Birth Disorder					
GI Disorder					
Heart Attack					
Hypertension					
Kidney Disease					
Migraine					
Seizure					
Stroke					
Other					

Pregnancy History (Female patients only)

Have you ever been pregnant? _____ YES _____ NO
If yes, complete below:

	Year	Live Birth?		Vaginal	Cesarean	Miscarriage	Abortion	Still Birth
		Yes	No					
#1								
#2								
#3								
#4								
#5								
#6								
#7								
#8								
#9								
#10								

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Surgical History

Appendix Removal ____________________
Bone Repair ____________________
Breast Biopsy ____________________
Cataract Surgery ____________________
Colon/Partial Colon ____________________
Removal (Colectomy) ____________________
Dilation & Curettage ____________________
Fistula Insertion ____________________
Foot Surgery (circle) Right Left
Gall Bladder Removal ____________________
Heart Bypass Graft ____________________
Heart Valve Replacement

Hernia Repair ____________________
Hip Surgery (circle) Right Left
Hysterectomy ____________________
Knee Surgery (circle) Right Left
Mastectomy (circle) Partial Modified
Total Radical
Prostate Removal ____________________
Skin Graft ____________________
Spleen Removal ____________________
Tonsillectomy ____________________
Wound Debridment ____________________
Other ____________________

Social History

Alcohol Use: FREQUENT SOCIAL NEVER Previous History of Alcohol Use: ____________________

Tobacco Use: SMOKING FORMER SMOKER NEVER SMOKED

Type: Cigarettes Cigars Other: ______________ Current Amount: ____________________

Previous History of Tobacco Use: ______________________Past Amt: ____________________

Caffeine Use: FREQUENT SOCIAL NEVER Explain: ____________________

Allergies

No known food/pet allergy: ☐ No known medication/drug allergy: ☐

Please list any food/pet allergies: ____________________

Please list any medication/drug allergies: ____________________

Current Medication

Do you currently have a Medi-port? ______ YES ________ NO

Medication/Dosage	Frequency	Medication/Dosage	Frequency
Medication/Dosage	Frequency	Medication/Dosage	Frequency
Medication/Dosage	Frequency	Medication/Dosage	Frequency
Medication/Dosage	Frequency	Medication/Dosage	Frequency

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Preferred Pharmacy Information

Pharmacy Name: ____________________________________ Phone #: ______________________ Fax #: ____________________

Address: ______________________________________ City/State/Zip: ____

Pharmacy Name: ____________________________________ Phone #: ______________________ Fax #: ____________________

Address: ______________________________________ City/State/Zip: ____

Mail-order Pharmacy: ________________________________ Phone #:________________________ Fax #: ____________________

Address: ______________________________________ City/State/Zip: ____