PATIENT REGISTRATION

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City/State/Zip: _____

Patient SSN: _____ Home Phone: _____

Patients Employer: _____ Work Phone: _____

Work Address: _____ City/State/Zip: _____

Nearest Relative: _____ Relationship: _____

Address: _____ Phone: _____

In Case of Emergency, please notify: _____ Phone: _____

Referred By: _____ Phone: _____

Primary Care/Family Physician: _____ Phone: _____

Insurance Information

Insured's Name: _____ Relationship/Self ____ Other _____

Insured's Address: _____ City/State/Zip: _____

Insured's Employer: _____ Employer's Phone: _____

(Photocopy Of Insurance Card Acceptable Substitution)

Primary Insurance Carrier: _____ Phone: _____

Claim's Address: _____ City/State/Zip: _____

_____ Policy Number: _____ Group: _____

Secondary Insurance Carrier: _____ Phone: _____

Claim's Address: _____ City/State/Zip: _____

_____ Policy Number: _____ Group: _____

I Hereby authorize and direst payment check(s) for benefits due me for the services rendered by Richard Neville,M.D. to be made directly to him regardless of my insurance benefits, if any.

I understand that I am financially responsible for the fees in full for services rendered.

I hereby authorize Richard Neville, M.D. to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance. I also authorize Richard Neville, M.D. to release information to me or to any hospital facility or physician whom I may be referred to by this office. I agree that this office may release records pertaining to my treatment to my insurance company or the third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan.

I hereby authorize the release of my medical records to Richard Neville, M.D. by any hospital, facility, or physician.

Patient(Parent/Guardian for minors)Signature: _____

Date Signed: _____

Medical History

Name: _____ Age: _____ Height: _____ Weight: _____

1. Do you have any allergies to drugs? _____ If yes, what drug: _____

_____

2. Any Latex allergy: _____ Any Non-drug Allergies: _____

3. Please list any previous surgeries & year (Estimates are okay)

- _____ Year: _____
- _____ Year: _____
- _____ Year: _____
- _____ Year: _____
- _____ Year: _____

4. Do you take any aspirin or medications containing aspirin (antiarthritics) at this time and if so, how much and how often? _____

5. List any prescription medications you are taking: _____

_____

_____

6. List all non - prescription and over the counter medications you are now taking: _____

_____

_____

7. Have you had or is there any family history of any of the following:

	Self	Family Member/Relationship
➢ Heart Disease	_____	_____
➢ Stroke	_____	_____
➢ Diabetes	_____	_____
➢ Cancer	_____	_____

8. Do you drink alcohol? _____

9. Do you smoke? _____ If yes, how many per day? _____

10. Do you have any problems/or history of easy bruising or prolonged bleeding? _____

11. List any other past medical history the doctor should know about: _____

_____

_____