Associated Family Physicians

SACRAMENTO OFFICE
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GALT OFFICE
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Galt, CA 95823
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Fax: (209) 745-9187

Office Use Only

Patient Acct # ____________

Registration Form

Name ______________________________ Date of Birth ____________

Address ______________________________
Street City State Zip Code

Phone ______________ Work ______________ Cell ______________

Marital Status: ☐ S ☐ M ☐ D ☐ W Gender: ☐ M ☐ F Spouse Name ______________

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Other ______________

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Other ______________

E-mail address ______________________________

Social Security # ______________ Driver's License # ______________

Occupation ______________ Employer ______________

Emergency Contact ______________ Relationship ______________ Phone ______________

Primary MD ______________ Referring MD ______________

PRIMARY INSURANCE

Name ______________

Group # ______________

ID # ______________

Subscriber ______________

SECONDARY INSURANCE

Name ______________

Group # ______________

ID # ______________

Subscriber ______________

OUR INSURANCE BILLING POLICY
We will bill your insurance(s) for services rendered by Associated Family Physicians, Inc. If your insurance plan requires a referral or authorization, we must have your referral or authorization on file prior to your visit. You are responsible for any balance not covered or authorized by your insurance(s).

I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO:
Associated Family Physicians, Inc.

I also authorize the release of any information about me that is necessary to process my insurance claims. A copy of this authorization may be used in place of the original authorization.

We understand that insurance coverage is very confusing to many people, and we are committed to helping you with any questions you may have. Please contact our business office at (916) 689-4111 if you have any questions about this authorization.

I have read and understand the policy stated above:

INSURED SIGNATURE: ______________________________ Date: ______________

MEDICATIONS

List of All Medications (include dose and frequency): Include over the counter medications

(1) ______________ (6) ______________

(2) ______________ (7) ______________

(3) ______________ (8) ______________

(4) ______________ (9) ______________

(5) ______________ (10) ______________

List of Allergies and Reactions: (Rash, Difficulty Breathing, Swelling, Nausea etc.)

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FAMILY HISTORY

FAMILY HISTORY	If Living: Age	If Living: Medical History (circle one)	If Deceased: Age at Death	If Deceased: Cause
Father ____	____	Heart Disease Stroke Diabetes Cancer None	____	____
Mother ____	____	Heart Disease Stroke Diabetes Cancer None	____	____
Siblings (First Names)				
____ ☐ M ☐ F	____	Heart Disease Stroke Diabetes Cancer None	____	____
____ ☐ M ☐ F	____	Heart Disease Stroke Diabetes Cancer None	____	____
____ ☐ M ☐ F	____	Heart Disease Stroke Diabetes Cancer None	____	____
____ ☐ M ☐ F	____	Heart Disease Stroke Diabetes Cancer None	____	____
____ ☐ M ☐ F	____	Heart Disease Stroke Diabetes Cancer None	____	____
Children (First Names)				
____ ☐ M ☐ F	____	Heart Disease Stroke Diabetes Cancer None	____	____
____ ☐ M ☐ F	____	Heart Disease Stroke Diabetes Cancer None	____	____
____ ☐ M ☐ F	____	Heart Disease Stroke Diabetes Cancer None	____	____
____ ☐ M ☐ F	____	Heart Disease Stroke Diabetes Cancer None	____	____
____ ☐ M ☐ F	____	Heart Disease Stroke Diabetes Cancer None	____	____

MEDICAL HISTORY

Medical History (Check if you have experienced any of the following problems in the last 6 months and explain if appropriate)

General Well-Being
- ☐ Fatigue/Weakness
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Weight Gain
- ☐ Weight Loss

Eyes
- ☐ Blurred or Double Vision
- ☐ Corrective Lenses
- ☐ Eye Disease or Injury
- ☐ Glaucoma

Ears, Nose, Mouth, Throat
- ☐ Difficulty Swallowing
- ☐ Hearing Difficulties
- ☐ Neck Injury
- ☐ Nose Bleeds
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Other Disease ____

Cardiovascular (Heart)
- ☐ Abnormal Heart Rhythms/Palpitations
- ☐ Arm, Neck or Jaw Pain
- ☐ Chest Pain
- ☐ Defibrillator/Type ____
- ☐ High Blood Pressure
- ☐ Leg Pain (claudication)
- ☐ Pacemaker/Type ____
- ☐ Prior Angiogram Date ____
- ☐ Prior Balloon Angioplasty/Stent Date ____
- ☐ Prior Heart Attack Date ____
- ☐ Prior Heart Surgery Date ____
- ☐ Prior Vascular Surgery or Procedure
- ☐ Other Disease ____
- ☐ Shortness of Breath
- ☐ Dizziness/Syncope
- ☐ Rheumatic Fever
- ☐ Murmur

Gastroenterology (Abdomen)
- ☐ Abdominal Pain or Heartburn
- ☐ Acid Reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Ulcers
- ☐ Intestinal Disease ____
- ☐ Gallbladder Disease
- ☐ Liver Disease ____
- ☐ Cirrhosis of the Liver
- ☐ Hepatitis
- ☐ Other Disease ____

Musculoskeletal
- ☐ Joint Pain
- ☐ Arthritis
- ☐ Back Injury or Surgery
- ☐ Muscle Problems
- ☐ Other Disease ____

Skin
- ☐ Rashes
- ☐ Ulcers
- ☐ Other Disease ____

Neurologic
- ☐ Alzheimer's Disease
- ☐ Brain Injury
- ☐ Convulsions/Seizures
- ☐ Dizziness
- ☐ Insomnia
- ☐ Memory Loss or Confusion
- ☐ Migraines or Headaches
- ☐ Numbness
- ☐ Stroke
- ☐ Weakness
- ☐ Other Disease ____

MEDICAL HISTORY continued

Respiratory (Lungs)
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Other Disease ____________________

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Psychosis
- ☐ Schizophrenic
- ☐ Other Disease ____________________

Endocrine
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Over Weight
- ☐ Thyroid Gland Disease
  Type ____________________

Infections
- ☐ Diphtheria
- ☐ Hepatitis Type
- ☐ Herpes Zoster (shingles)
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Scarlet Fever

Oncology
- ☐ Cancer
  Type ____________________
- ☐ Cancer Treatment
  Type ____________________

Urinary
- ☐ Bladder Disease
- ☐ Difficult or Painful Urination
- ☐ Incontinence
- ☐ Kidney Disease ____________________
- ☐ Kidney Stones
- ☐ Other Disease ____________________

Hematology (Blood Disorders)
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clots
- ☐ Transfusions
- ☐ Other Disease ____________________

Extremities
- ☐ Swelling
- ☐ Other Disease ____________________

For Women
- ☐ Breast Disease
- ☐ Post Menopausal
- ☐ Uterine Disease
- ☐ Vaginal Bleeding
- ☐ Other Disease ____________________

For Men
- ☐ Breast Disease
- ☐ Prostate Disease
- ☐ Sexual Dysfunction
- ☐ Other Disease ____________________

List All Current Symptoms

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List All Surgeries and Approximate Dates

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List All Serious Injuries and/or Accidents

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SOCIAL HISTORY

Tobacco Use

☐ Current every day smoker

☐ Current some day smoker

☐ Never smoker

☐ Former smoker

☐ Unknown if ever smoked

If Yes, Number of years and daily use

☐ Cigarettes ____________________

☐ Cigars ____________________

☐ Pipe ____________________

☐ Chewing Tobacco ____________________

If you have quit, how old were you when you quit? ____________________

What was your daily use at that time? ____________________

Alcohol Use

☐ Never Drank

☐ Number of alcoholic drinks in a week ____________________

Caffeine Use: (Coffee, Soda, Tea)

☐ Never use caffeine

☐ Number of caffeine drinks in a week ____________________

Recreational Drug Use

☐ Never used

☐ Type and Frequency ____________________

Exercise Regimen ____________________

Do you have Chest Pain with exercise ☐ Yes ☐ No If yes ☐ Mild ☐ Moderate ☐ Severe

Questions for your physician:

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