CAVALLARO
FAMILY PRACTICE

Patient Registration Form

Name | Preferred Name

Address | SSN

City | State | Zip Code | Phone (H)

Country | Phone (W)

email | Birthdate

Employer | Marital Status ☐ Married ☐ Single ☐ Divorced

Sex ☐ Male ☐ Female

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Name | SSN

Address | Phone (H)

City | State | Zip Code | Phone (W)

email | Birthdate

Employer | Sex ☐ Male ☐ Female

Relationship to Patient

INSURANCE

Primary | Group # | ID #

Address | City | State | Zip Code

Subscriber Name | SSN | Birthdate

Secondary | Group # | ID #

Address | City | State | Zip Code

Subscriber Name | SSN | Birthdate

Emergency Contact | Phone (H) | Phone (W)

AUTHORIZATION INFORMATION

The undersigned, as patient (or as parent or guardian of the patient), so hereby authorized the attending physician/practitioner to medically and/or surgically manage the treatment of the above named patient and to
provide such surgical and/or medical treatment, which, in the physician/practitioners judgement, is deemed necessary for the benefit of the patient.

Signature _____ Date _____

ASSIGNMENT OF BENEFITS AUTHORIZATION

The undersigned, as patient (or as parent or guardian of the patient), authorizes and assigns payment of benefits due under terms of any insurance policy or policies that may cover the medical procedure performed on the patient at the address designated by provider on any claim form submitted to patient's insurance carrier. Patient understands and agrees that patient is financially responsible for charges not covered by their Insurance policy.

Signature _____ Date _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY MEMBERS & FRIENDS

I hereby authorize Cavallaro Family Practice (CFP) to release my patient information described below to:

☐ All of my family members ☐ Spouse ☐ Mother ☐ Father ☐ Children

☐ Other family members: _____

☐ The following persons: _____

Documents/Information to be Released

Information/documents regarding medical treatment of the patient including diagnosis, procedures and test results.

Purpose of Disclosure:

At the request of the individual

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (HIPAA) govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to the attention of "The Compliance Officer".

I understand that I am not required to sign this Authorization and that CFP may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

l hereby acknowledge receipt of this Authorization.

I DO / DO NOT GIVE PERMISSION (Circle One) to Cavallaro Family Practice LLC to leave information on my answering machine and with my family members in regard to appointments, referrals and test results.

_____ _____

Signature of Individual or Personal Representative **Description of Personal Representative's Authority**

Date of Authorization _____

Name ☐ Male ☐ Female Birthdate

How did your hear about Cavallaro Family Practice ? (Check all that Apply)

☐ Internet ☐ Advertisement ☐ Family member ☐ Friend ☐ Other:

PERSONAL HEALTH HISTORY

Please return this form to Cavallaro Family Practice by mail or fax in order to schedule your visit. Your practitioner must review it in preparation for that visit. All information will be kept strictly confidential. Mark any areas you may have difficulty completing and we will be happy to assist you during your first visit. Please be as complete and thorough as possible, your answers will help guide the practitioner during your first visit. Please provide any related laboratory, X·ray or other medical records.

Current Health Situation

Reason for today's visit?

Past Medical History

Approximate date of last medical exam:

Are you presently under the care of another physician? ☐ No ☐ Yes

If Yes, Provide physician's name:

For what

Medications/Supplements

Please list any vitamins, minerals and/or herbal supplements you take and why. If more room is necessary, please use the back of this form or attach a separate list.

1.		2.		3.	
4.		5.		6.	

Please list any prescriptions and/or over the counter medicines you take and why. Also please list dose and frequency of use

Medication		Dose		Frequency	
Medication		Dose		Frequency	
Medication		Dose		Frequency	
Medication		Dose		Frequency	
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Medication		Dose		Frequency	

Family History

Please include Name, Age, Sex, Living/Deceased, Health Problems/cause of Death

Father's Name Age

☐ Living
☐ Deceased

Cause of Death

Health Problems

Mother's Name Age

☐ Living
☐ Deceased

Cause of Death

Health Problems

Sibling's Name Age

☐ Male
☐ Female

☐ Living
☐ Deceased

Cause of Death

Health Problems

Sibling's Name Age

☐ Male
☐ Female

☐ Living
☐ Deceased

Cause of Death

Health Problems

Sibling's Name Age

☐ Male
☐ Female

☐ Living
☐ Deceased

Cause of Death

Health Problems

Family History Continued

Spouse Name Age ☐ Male ☐ Female

☐ Living ☐ Deceased Cause of Death

Health Problems

Child's Name Age ☐ Male ☐ Female

Health Problems

Child's Name Age ☐ Male ☐ Female

Health Problems

Health History

☐ Allergies Drug Sensitivities

Smoking History

☐ Never Smoke ☐ Currently Smoke Amount ☐ Use to Smoke Amount Until

Alcohol History

☐ Never/rarely ☐ Currently Drink Average/amount

Drug History

☐ Never ☐ Past Use of

Occupation

Current Occupation Retired (yr)

Marital Status

☐ Married ☐ Divorced ☐ Partnered ☐ Single ☐ Widowed

Live with

Method of Contraception (you or your partner

Surgical History

Surgery/Hospitalization		Start Date	
Surgery/Hospitalization		Start Date	
Surgery/Hospitalization		Start Date	

Date of Last:

Chest X-Ray		EKG		Blood Test		Stool for Blood	
Colon Exam		TB Test		Other		Prostate Exam	
HIV Test		Pap		Eye Exam		Mammogram	

Immunizations received in the past 10 Years:

- ☐ Tetanus
- ☐ Flu
- ☐ Pneumonia
- ☐ Hepatitis B
- ☐ Hepatitis A
- ☐ Other
- ☐ Mumps
- ☐ Measles
- ☐ Rubella (German Measles)

Childhood Immunizations:

- ☐ Polio
- ☐ Pertussis
- ☐ Diptheria
- ☐ Polio

Women's Health Medical History (Women Only)

Menstral History

Age at onset

Regular ☐ Yes ☐ No ☐ Varies

Cycle # of days from 1st day-next 1st day

Flow ☐ Heavy ☐ Medium ☐ Light

Clots Passed ☐ Yes ☐ No

Premenstrual Symptoms

Date of Last Period

Date of Last Pelvic Exam

Date of Pap

Pap Result

Vaginal Discharge ☐ Yes ☐ No

Color Amount

Any itching of vaginal area ☐ Yes ☐ No

Breasts

- ☐ Breast pain/discharge
- ☐ Lump in breast

Pregnancies

How many Pregnancies

How many children born alive

How many stillbirths

How many cesarean sections

How many miscarriages

How many Abortions

Pregnancy Complications ☐ Yes ☐ No ☐ N/A

Describe Pregnancy Complications

Other

Medical History: Check only those with which you have had a significant problem (currently or over the past year). If Yes, please explain.

Constitutional:

- ☐ Significant 10lb weight gain/loss
- ☐ Problems with Apetitie
- ☐ Energy level too low/too high
- ☐ Changes in stress/mood level
- ☐ Unexplained fever
- ☐ Heat/Cold intolerance
- ☐ Unusual thirst
- ☐ Sleep Problems

Eyes/Ears/Nose/Throat

- ☐ Decreased hearing
- ☐ Ringing noises in ears
- ☐ Nasal congestion
- ☐ Sores in mouth/bleeding gums
- ☐ Impaired taste
- ☐ Any visual change

Neurological

- ☐ Lightheadedness/fainting
- ☐ Unusual headaches
- ☐ Problems with balance

Cardiovascular/Respiratory

- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Swelling in legs
- ☐ Awake with sudden breathlessness
- ☐ Unusual cough/sputum production

Musculoskeletal

- ☐ Muscle aches/cramps
- ☐ Muscle fatigue
- ☐ Joint stiffness/pain/swelling

Gastrointestinal

- ☐ Unusual nausea/vomiting
- ☐ Unusual diarrhea/constipation
- ☐ Change in stool (size/color/shape)
- ☐ Rectal Bleeding
- ☐ Abdominal Pain
- ☐ Gas Bloating
- ☐ Heartburn
- ☐ Trouble swallowing/food getting stuck

Genitourinary

- ☐ Difficulty or pain with urination
- ☐ Blood in urine
- ☐ Sexual dissatisfaction/difficulty
- ☐ Difficulty controlling urine
- ☐ Difficulty controlling bowel movements

Skin

- ☐ Unusual rashes/sores/lesions
- ☐ Unusual bruising

Infectious Disease

- ☐ Parisites
- ☐ HIV
- ☐ Chicken Pox
- ☐ Hepatitis
- ☐ Lyme Disease
- ☐ Whooping cough
- ☐ Diptheria
- ☐ TB
- ☐ Rheumatic fever
- ☐ Venereal disease
- ☐ Meningitis
- ☐ Other

Men's Health Medical History (Men Only)

Enlarged Prostate	☐ Yes	☐ No
Elevated PSA	☐ Yes	☐ No
Problems with erections	☐ Yes	☐ No
Problems with orgasams	☐ Yes	☐ No
Urethral discharge	☐ Yes	☐ No

Risk Assessment

1. Do you ever drive without wearing seatbelts ☐ No ☐ Yes

2. Are there firearms in the home ☐ No ☐ Yes

If yes, specify what safety measures are used

3. Do you exercise regularly ☐ No ☐ Yes

If yes, specify type of exercise

4. Significant weight loss/gain in the past year ☐ No ☐ Yes

If yes, specify type weight fluctuation

5. Have you ever worked with hazardous chemicals, asbestos, etc... ☐ No ☐ Yes

If yes, specify hazardous matierals

6. Are there any hazards at your current working environment ☐ No ☐ Yes

7. Do you enjoy work ☐ No ☐ Yes

8. Are you in a relationship in which you have been physically, sexually or emotionally injured by your partner ☐ No ☐ Yes

9. Do you feel afraid of your partner ☐ No ☐ Yes

10. Have you ever been concerned that you may have an eating disorder ☐ No ☐ Yes

11. Have you ever been concerned that you may have a problem related to drugs ☐ No ☐ Yes

12. Have you ever been concerned that you may have a problem related to alcohol ☐ No ☐ Yes

13. Have you ever shared a needle with anyone else ☐ No ☐ Yes

14. Have you ever received a blood transfusion ☐ No ☐ Yes

15. Have yo ever engaged in any activity that might put you at risk for HIV ☐ No ☐ Yes

16. Do you wish to be tested for HIV ☐ No ☐ Yes

17. Do you have a living will ☐ No ☐ Yes

18. Do you have a donor card ☐ No ☐ Yes

19. Do you generally feel well ☐ No ☐ Yes

20. If not, when was the last time that you did feel