

REGISTRATION: PLEASE PRINT – EVERYTHING MUST BE FILLED OUT

PATIENT INFORMATION

Patient: _____
FIRST Name LAST Name Initial

Social Security Number: _____

Date Of Birth: _____ Sex: F M

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

E-mail: _____

How do you prefer to be contacted: Home Phone Cell Phone E-mail Work Phone

Is it alright to leave message on the phone: YES NO

Marital Status: Single Married Divorced Widowed

GUARANTOR DETAILS (Skip section if you are the guarantor)

Relation to Patient: _____

Name: _____
Last Name First Name

Social Security Number: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

EMERGENCY CONTACT

Relation to Patient: _____

Name: _____
Last Name First Name

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

PRIMARY INSURANCE

Insurance Company: _____

Person Responsible for Account: _____
Last Name First Name

Relation to Patient: _____ Birth Date: _____ SS#: _____

SECONDARY INSURANCE

Insurance Company: _____

Person Responsible for Account: _____
Last Name First Name

Relation to Patient: _____ Birth Date: _____ SS#: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with:

Name of Insurance Company (ies)

I understand that I am financially responsible for all appropriate charges.

I hereby authorize Dr. Zorica Mercadante and staff to release to the above insurance company all information necessary to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions.

I understand that it is ultimately my responsibility to know my coverage benefits.

Responsible Party Signature

Date

HISTORY FORM

OFFICE OF DR. MERCADANTE

NAME: _____

Please answer this questionnaire to the best of your ability. All the information is strictly confidential and is only to be used to provide you with the best care possible.

MEDICAL HISTORY:

Check off all that have ever applied to you

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Indigestion/GERD/reflux |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Ulcer disease |
| <input type="checkbox"/> Diabetes / high sugar | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Heart failure/ congestive heart failure | <input type="checkbox"/> Lactose intolerance |
| <input type="checkbox"/> Arrhythmia/ irregular heart rate | <input type="checkbox"/> Crohn's/Ulcerative colitis/inflammatory bowel disease |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Sprue/Celiac disease |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Liver problem/hepatitis |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Polycystic ovary syndrome |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Cyst/s on ovary |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Bladder conditions | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Enlarged prostate | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Cancer of _____ |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Benign Tumor |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Meningioma | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> History of head injury | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Bipolar disorder |
| <input type="checkbox"/> Seizure history | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Low thyroid/hypothyroid | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> High thyroid | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Parathyroid disease | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Lyme's disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Lupus/connective tissue disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Clotting problems |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> DVT (clot in legs) |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Pulmonary embolus (clot in lung) |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Other breathing problems | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Radiation exposure | <input type="checkbox"/> Other: |

SURGICAL HISTORY (list all the surgeries you have ever had including the year):

PRESCRIPTION MEDICATIONS / SUPPLEMENTS/ OTC MEDS:

MEDICATION ALLERGIES:

FOOD ALLERGIES:

General testing (list if and when you have had any of the following):

BLOOD WORK:

URINE:

CHEST X-RAY:

ECG:

STRESS TEST:

HOLTER MONITOR:

ECHO:

MAMMOGRAM:

BONE DENSITY TEST:

COLONOSCOPY:

UPPER ENDOSCOPY:

FLU SHOT:

PNEUMONIA SHOT:

OTHER VACCINES:

List doctors you see:

GYN:

CARDIOLOGY:

PULMONARY:

GASTROINTESTINAL:

RHEUMATOLOGIST:

ENDOCRINOLOGIST:

ALLERGIST:

SURGEON:

ORTHOPEDIST:

EYE DOCTOR:

SMOKING HISTORY:

- Never smoked
- Quit in year: _____ Smoked for # of years: _____
Circle: 1/2 pack / 1pack / 2packs
- Currently smoking

ALCOHOL USE:

- Never drink
- Drinks per week: _____ Type: _____
- Recovering from alcohol

DRUG USE:

FAMILY HISTORY (list the health problems of your family):

MOTHER:

FATHER:

SISTERS:

BROTHERS:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Other blood-relatives with health problems:

OCCUPATIONAL HISTORY:

What do you do for a living:

Any exposure to fumes/chemicals/asbestos:

REVIEW OF SYSTEMS				
<p>GENERAL</p> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Night sweats only <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Daytime sleepiness <input type="checkbox"/> Feel cold all the time <input type="checkbox"/> Feel hot all the time <input type="checkbox"/> Swollen glands <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Insomnia <p>SKIN</p> <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Hives <input type="checkbox"/> Easy bruising <input type="checkbox"/> Dryness <input type="checkbox"/> Change in skin color <input type="checkbox"/> Change in hair <input type="checkbox"/> Change in nails <input type="checkbox"/> Lumps <input type="checkbox"/> Abnormal moles <p>HEAD</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Focal pain	<p>EYES</p> <input type="checkbox"/> Change in vision <input type="checkbox"/> Double vision <input type="checkbox"/> Pain <input type="checkbox"/> Injuries <input type="checkbox"/> Unusual sensations <input type="checkbox"/> Severe dryness <p>EARS</p> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing <input type="checkbox"/> Pain <p>NOSE</p> <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Injury <input type="checkbox"/> Discharge/drip <input type="checkbox"/> Loud snoring <input type="checkbox"/> Loss of smell <p>MOUTH/THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Sore throats frequent <input type="checkbox"/> Burning in tongue <input type="checkbox"/> Loss of taste <input type="checkbox"/> Hoarseness <p>NECK</p> <input type="checkbox"/> Lumps <input type="checkbox"/> Pain <p>CHEST</p> <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Pain <input type="checkbox"/> Short of breath <input type="checkbox"/> Coughing up blood	<p>CARDIAC</p> <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart racing <input type="checkbox"/> Pain <input type="checkbox"/> Short of breath <p>VASCULAR</p> <input type="checkbox"/> Pain in legs, calves, thighs with walking <input type="checkbox"/> Swelling of legs <input type="checkbox"/> Varicose veins <input type="checkbox"/> Phlebitis <input type="checkbox"/> Loss of hair on legs <input type="checkbox"/> Ulcers on skin <input type="checkbox"/> Loss of color or cold <p>BREAST</p> <input type="checkbox"/> Lumps <input type="checkbox"/> Discharge <input type="checkbox"/> Pain <input type="checkbox"/> Tenderness <p>GASTROINTESTINAL/ ABDOMINAL</p> <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Pain <input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool <input type="checkbox"/> Change in stool <input type="checkbox"/> Reflux/indigestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Bloating/gas	<p>URINARY</p> <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Difficult to start voiding <input type="checkbox"/> Incomplete emptying <input type="checkbox"/> Incontinence <input type="checkbox"/> Pain <input type="checkbox"/> Blood in urine <input type="checkbox"/> Change in color/odor <input type="checkbox"/> Urinating during night <p>MALE</p> <input type="checkbox"/> Lesions on penis <input type="checkbox"/> Discharge <input type="checkbox"/> Difficulty with erections <input type="checkbox"/> Pain <input type="checkbox"/> Scrotal masses <input type="checkbox"/> Hernias <input type="checkbox"/> Prostate problems <input type="checkbox"/> Low libido <p>FEMALE</p> <input type="checkbox"/> Lesions <input type="checkbox"/> Itching <input type="checkbox"/> Severe dryness <input type="checkbox"/> Discharge <input type="checkbox"/> Pain on intercourse <input type="checkbox"/> Fertility problems <input type="checkbox"/> Irregular periods <input type="checkbox"/> Severe menstrual pain <input type="checkbox"/> Fibroids <input type="checkbox"/> Ovarian cysts <input type="checkbox"/> Low libido	<p>MUSCULOSKELETAL</p> <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Paralysis <input type="checkbox"/> Muscle stiffness <input type="checkbox"/> Restless legs <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Back problems <input type="checkbox"/> Unsteadiness <p>NEUROLOGIC</p> <input type="checkbox"/> Fainting <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Tingling / burning <input type="checkbox"/> Tremors <input type="checkbox"/> Memory loss <input type="checkbox"/> Speech problem <input type="checkbox"/> Balance problem <input type="checkbox"/> Nervousness <input type="checkbox"/> Mood changes <input type="checkbox"/> Frequent anger spells <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety / panic <input type="checkbox"/> Hallucinations <input type="checkbox"/> Disorientation <input type="checkbox"/> Urge to use drugs or alcohol <input type="checkbox"/> Road rage