Patient Registration Form

Date of Appointment:	

Patient Informa	ation								
Patient's First Name		Middle Name		Last Name	(as	it appears on insurance card or IE			
Sex	Marital Sta	ntus	Date of Birth (Age)		Social Security	Social Security Number			
Patient's Address				City		State	Zip		
							,		
Home Phone			Mobile Phone		Email Address	Email Address			
Referred by			Primary Care Physician		Primary Care P	hysician Phor	ne		
Dis assessed as		Disames and Dis		Discourse Address					
Pharmacy Pho		one Pharmacy Address							
Patient Employer/Se	chool Informatio	n							
Employer/School			Occupation		Employer/Scho	Employer/School Phone			
Employer/School Addi	ess			City		State	Zip		
				- 2					
Emergency Contact									
Emergency Contact Na	ame		Emergency Contact Phone		Relation to Pat	Relation to Patient			
			-						
Billing and Insu	ırance								
Primary Health Insu	rance								
Insurance Company				Plan					
Plan Name		Group Numbe	er	Insured's Employer/School					
Insured's Name (as it a	nsured's Name (as it appears on insurance card or ID)			Relation to Patient		Insured's Phone Number			
,		,							
Insured's Address				City		State	Zip		
Insured's Social Security Number Insured's Birth		ndate							
Secondary Health In	nsurance								
Insurance Company	isurance			Plan					
Plan Number	Group Number		er	Insured's Employer/Sc	Insured's Employer/School		Insured's Social Security Number		
Insured's Name (as it appears on insurance card or ID)			Relation to Patient	Relation to Patient		Insured's Phone Number			
Responsible Party									
Billing Name (if other t	han patient)			Phone	Relation to Pat	Relation to Patient			
Address				City		State	7:n		
Address				City		State	Zip		
to communicate v procedures or tes	vith referring st performed a	physicians an t additional co	d to process insurar ost. I authorize direc	ncy Practices. I author nce claims. In accorda t payment of covered urance coverage. Pay	ance with medica benefits to the p	ıl treatmen rovider of	professional		
Signature of Patient or Authorized Guardian			_	Date					

Current Medications	Name		Gender Age	Date	of Appointment:			
Ans brings you to the office today? Ans you currently taking any blood thinners? \bigs \b			Zender //ge	Current Medication				
What medications are you currently taking? Name								
Name	What brings you to the office	e today?		Are you currently taking	any blood thinners?	Yes No		
Name				What medications are yo	u currently taking?			
Name Dosage Frequency Name Reaction Reaction Reaction Reaction Reaction Reaction Name Reaction Name Reaction Name Reaction Name Reaction Reac				Name		Dosage	Frequency	
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Allergies Do you have any other allergies? Name Reaction Nate Reaction Nate Reaction Reaction Recursion Simulation Nate Reaction Nate Reaction Nate Reaction Recursion Recursion Reaction Recursion				Name				
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Do you have any other allergies? Name				Allamaiaa		-		
Name Reaction Nation Reaction Nation Reaction Nation Neck Pain Nation Neck Pain Name Nation Neck Pain Nation								
Name Reaction Name Reaction Name				Do you have any other a	llergies?			
Name Reaction Name Reaction Reaction				Name	Reaction			
Do you have any of the following? Bledeling Gums				Name	Reaction			
Bleeding Gums				Name	Reaction			
Bleeding Gums Decreased Sense of Taste Earaches Blurred Vision Difficulty Breathing Ear Discharge Itching in Ears Persistent Cough Sonoring Cicking in Ears Difficulty Swallowing Facial Paralysis Lumps / Knots in Neck Persistent Runny Nose Throat Pain Nasal Obstruction Recurring Soor Throat Pain Vision Halos Persistent Runny Nose Throat Pain Nasal Obstruction Recurring Soor Throat Vision Halos Post Masal Obstruction Recurring Soor Throat Post Masal Obstruction Recurring Soor Throat Post Masal Obstruction Recurring Soor Throat Vision Halos Post Masal Obstruction Recurring Soor T	ENT							
Blurred Vision Difficulty Breathing Ear Discharge Itching in Ears Persistent Cough Snoring Clossed Eyes Difficulty Swallowing Facial Paralysis Lumps / Knots in Neck Persistent Rump / Knots Throat Pain Vision Halos Pacial Paralysis Lumps / Knots in Neck Persistent Rump / Knots Throat Pain Vision Halos Pacial Paralysis Lumps / Knots in Neck Persistent Rump / Knots Throat Pain Vision Halos Pacial Paralysis Lumps / Knots in Neck Persistent Rump / Knots Throat Pain Vision Halos Pacial Paralysis Lumps / Knots in Neck Persistent Rump / Knots Throat Pain Vision Halos Pacial Paralysis Lumps / Knots in Neck Persistent Rump / Knots Throat Pain Vision Halos Pacial Paralysis Lumps / Knots in Neck Persistent Rump / Knots Throat Pain Vision Halos Pacial Paralysis Lump / Knots Pacial Paralysis Lumps / Knots Throat Pain Vision Halos Pacial Paralysis Lump / Knots Pacial Paralysis Lump / Knots Pacial Paralysis Lump / Knots Pacial Paralysis Lump / Lump	Do you have any of the follo	owing?						
Cilcking in Ears Difficulty Swallowing Pacial Paralysis Lumps / Knots in Neck Persistent Runny Nose Throat Pain Crossed Eyes Dizziness Hay Fever Nasal Obstruction Recurring Sore Throat Vision Halos Past Medical History Neck Pain Ringing in Ears Vision Halos Ringing in Ears Vision Halos Past Medical History Neck Pain Ringing in Ears Vision Halos Ringing in Ears Ringing in Ears Standard Vision Halos Ringing in Ears Ringing in Ears Standard Ringing in Ears Ringing in Ears Standard Ringing in Ears	_			_		Sinu	is Problems	
Crossed Eyes Dizziness Decreased Sense of Smell Double Vision Halos Decreased Sense of Smell Double Vision Halos Neck Pain Ringing in Ears Past Medical History Hoursness Neck Pain Ringing in Ears Ringin in Ears							_	
Decreased Sense of Smell Double Vision Hoarsness Neck Pain Ringing in Ears Ringing in Ea	_							
Past Medical History	-					at Visi	on Halos	
Alcoholism Back Problems Ear Problems Ear Problems Eating Disorder Eating Disorder High Blood Pressure Migraines Stomach Ulcer High Cholesterol Ostomach Pneumonia Thyroid Disorder Polio Tuberculosis Ulcer University Veneumonia Thyroid Disorder Polio Tuberculosis Ulcer University No Veneumonia Thyroid Disorder Polio Tuberculosis No Veneumonia Thyroid Disorder Polio Thyroid Disorder Polio Thyroid Disorder Polio Thyr	Past Medical History	Bouble vision	Hoarsness	Neck Falli	Ringing in Ears			
Allergies Bleeding Disorder Eating Disorder High Blood Pressure Migraines Stomach Ulcer Anemia Blood Disease Epilepsy High Cholesterol Osteoporosis Substance Abuse Anxiety Disorder Blood Transfusion Glaucoma Joint Disorder Pneumonia Thyroid Disorder Arthritis Cancer Gout Kidney Disorder Polio Tuberculosis Asthma Diabetes Heart Disease Liver Disorder Rheumatic Fever Venereal Disease AIDS / HIV Depression Heart Problems Women Only Are you pregnant? Are you breastfeeding? Are you pregnant? Are you breastfeeding? Yes No Yes No Lifestyle Factors Have you ever smoked? Yes No # packs/day Do you smoke now? Reason Date Yes No # packs/day Do you use recreational drugs? # times/week How much alcohol do you drink per week? # drinks/week How much caffeine do you drink per day? # drinks/day Health Information	Have you ever had any of the	ne following?						
Anemia Blood Disease Epilepsy High Cholesterol Osteoporosis Substance Abuse Anxiety Disorder Blood Transfusion Glaucoma Joint Disorder Pneumonia Thyroid Disorder Arthritis Cancer Gout Kidney Disorder Polio Tuberculosis Ashma Diabetes Heart Disease Lurg Disease Stroke Women Only Hospitalizations & Surgeries Women Only Are you pregnant? Are you breastfeeding? Yes No Yes No Reason Date Have you ever smoked? Have you ever smoked? Yes No # packs/day Do you smoke now? Reason Date Do you use recreational drugs? Reason Date How much alcohol do you drink per week? # drinks/week How much caffeine do you drink per day? # drinks/day Health Information	Alcoholism	Back Problems	Ear Problems	Hepatitis - A, B, or C	Measles	Skin	Disorder	
Anxiety Disorder Blood Transfusion Glaucoma Joint Disorder Pneumonia Thyroid Disorder Arthritis Cancer Gout Kidney Disorder Polio Tuberculosis Cancer Season Date Women Only Are you pregnant? Are you breastfeeding? Yes No Yes No Lifestyle Factors Have you ever smoked? Yes No # of years # packs/day Do you use recreational drugs? Reason Date Yes No types? # times/week How much alcohol do you drink per week? # drinks/week How much alcohol do you drink per day? # drinks/week How much alcohol do you drink per day? # drinks/day Health Information	Allergies	Bleeding Disorder	Eating Disorder	High Blood Pressure	Migraines	Stor	nach Ulcer	
Arthritis	Anemia	Blood Disease	Epilepsy	High Cholesterol	Osteoporosis	Sub	stance Abuse	
Asthma Diabetes Heart Disease Liver Disorder Rheumatic Fever Venereal Disease Stroke Hospitalizations & Surgeries Reason Date Yes No Yes No Yes No Reason Date Have you ever smoked? Reason Date Ves No # of years # packs/day Do you us moke now? Reason Date Date Pyes No # packs/day Date No you smoke now? Reason Date Date Date How much alcohol do you drink per week? Reason Date How much caffeine do you drink per day? ## drinks/day Health Information	Anxiety Disorder	Blood Transfusion	Glaucoma	Joint Disorder	Pneumonia	Thy	roid Disorder	
AIDS / HIV Depression Heart Problems Lung Disease Stroke Women Only Are you pregnant? Are you breastfeeding? Are you pregnant? Are you pregnant? Are you pregnant? Are you pregnant? Are you breastfeeding? Are you pregnant? Are you pregnant? Are you breastfeeding? Are you pregnant? Are you pregnant? Are you pregnant? Are you pregnant? Are you breastfeeding? Are you breastfeeding? Are you pregnant? Are you pregnant? Are you pregnant? Are you breastfeeding? Are you breastfeeding? Are you breastfeeding? Are you pregnant? Are you breastfeeding. Are you breastfeedi	Arthritis	Cancer	Gout	Kidney Disorder	Polio	Tube	erculosis	
Hospitalizations & Surgeries Reason Date	Asthma	Diabetes	Heart Disease	Liver Disorder	Rheumatic Fever	Ven	ereal Disease	
Are you pregnant? Are you breastfeeding? Yes No Yes No Are you breastfeeding? Yes No Are you breastfeeding? Yes No Yes No Are you breastfeeding? Yes No Yes No Yes No Yes No Yes No Are you breastfeeding? Yes No Yes No Yes No Are you breastfeeding? Yes No Yes No Yes No Weason Date Do you smoke? Yes No # of years # packs/day Do you smoke now? Yes No # packs/day Do you use recreational drugs? Yes No types? # times/week How much alcohol do you drink per week? # drinks/week How much caffeine do you drink per day? # drinks/day Health Information	AIDS / HIV	Depression	Heart Problems	Lung Disease	Stroke			
Are you pregnant? Are you breastfeeding? Yes No Yes No Are you breastfeeding? Yes No Are you breastfeeding? Yes No Yes No Are you breastfeeding? Yes No Yes No Yes No Yes No Yes No Are you breastfeeding? Yes No Yes No Yes No Are you breastfeeding? Yes No Yes No Yes No Weason Date Do you smoke? Yes No # of years # packs/day Do you smoke now? Yes No # packs/day Do you use recreational drugs? Yes No types? # times/week How much alcohol do you drink per week? # drinks/week How much caffeine do you drink per day? # drinks/day Health Information	Hospitalizations & Su	raeries		Women Only				
No Yes		. 90.1.00						
Reason Date Reason	Reason		Date				ng?	
Lifestyle Factors Have you ever smoked? Have you ever smoked? Yes No # of years # packs/day Do you smoke now? Reason Date Do you smoke now? Reason Date Do you use recreational drugs? Reason Date Yes No types? # times/week How much alcohol do you drink per week? # drinks/week How much caffeine do you drink per day? # drinks/day Health Information	Reason		Date					
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Yes No # of years	Reason							
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Family History Details: How much caffeine do you drink per day? # drinks/day Health Information			-	a anim por wook:				
# drinks/day # drinks/day Details: # drinks/day # drinks/day Health Information								
Family History Details: Health Information						_		
Details:	Family History					-		
Your Height Your Weight	Details:							
				Your Height	Your	Weight		

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