Patient Registration

First Name_____ Middle_____ Last _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____Sex _____ SS# _____

Phone # (_____) _____-_____ Cell # (_____) _____-_____

Email _____

Race _____ Ethnicity **(Circle One)** Hispanic / Non Hispanic

Preferred Language _____

Employed by _____

Work # _____Ext._____

Preferred Pharmacy _____

Drug Allergies _____

Single_____ Married_____ Widowed _____ Divorced _____

Name of Spouse _____

Date of birth_____ SS# _____

Employed by _____

Work # _____ Cell # _____

Children

_____ Age _____

_____ Age _____

_____ Age _____

Medicare # _____

OR

Primary Insurance _____

Insured's Name _____

Insured's Date of Birth _____SS#_____

Policy # _____ Group # _____

Secondary Insurance _____

Insured's Name _____

Insured's Date of Birth _____SS#_____

Policy # _____ Group # _____

Emergency Contact Name/# _____

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and any other plan to Aaron C. Polk, Jr., M.D. and/or Carl A. Davis, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and to request a review of claim.

Signed _____ Date _____

Family History

Relative	Disease	Age

Place A Check For Any Condition Which Applies To A Blood Relative

	Condition	Who
☐	Alcohol/Drug Abuse	
☐	Allergies/Asthma	
☐	Arthritis/Gout	
☐	Bleeding Disorder	
☐	Cancer Type	
☐	Diabetes	
☐	Epilepsy/Seizures	
☐	Glaucoma	
☐	Heart Disease	
☐	High Blood Pressure	
☐	High Cholesterol	
☐	HIV/AIDS	
☐	Kidney/Disease	
☐	Mental Illness	
☐	Migraine Headaches	
☐	Sickle Cell Condition	
☐	Stroke	
☐	Suicide/Depression	
☐	Thyroid Disease	
☐	Other	

The most interesting thing about me is _____

_____

_____

_____

_____

_____

Patient Signature:_____

Immunization History

Have you had:			Date
Chicken pox or Shot	☐ Yes	☐ No	
Hepatitis B Series or Shot	☐ Yes	☐ No	
Influenza Shot	☐ Yes	☐ No	
Pneumonia Shot	☐ Yes	☐ No	
Rubella Shot or Blood Test	☐ Yes	☐ No	
Tetanus Shot	☐ Yes	☐ No	

Questions for Women Only:

Menstration:

Age Periods Began: _____

How Often: _____

Last Menstrual Period: _____

PMS Symptoms: ☐ Yes ☐ No

Birth control ☐ Yes ☐ No

Pregnancies:

Total number: _____ Full Term: _____

Premature: _____ Miscarriages: _____

Abortions: _____ Tubal Pregnancies: _____

Complications: _____

Diet, Exercise, & Habits:

Do you follow a special diet? _____

Weight? Current _____Desired_____ 1 yr ago_____

What kind of exercise do you do and how often?

_____

_____

Tobacco Use:

Do you smoke? ☐ Yes ☐ No

If yes, what type? _____

Have you quit smoking? ☐ Yes ☐ No

Do you use other tobacco products? ☐ Yes ☐ No

If yes, what type? _____

How much? _____

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No

If yes, what type? _____

Has anyone ever expressed concerns about your alcohol use? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Religious Affiliation: _____

Highest Education achieved?_____

Previous jobs? _____

Exposure to hazardous conditions/substances at work?

_____

Do you have a living will? ☐ Yes ☐ No

Are you an organ donor? ☐ Yes ☐ No

Physican Signature: _____

Confidential Health History Questionnaire - Past Medical History

Name: _____ Nickname: _____

Date of Birth: _____ Date: _____

Allergies

None ☐

(List any allergies to medicines or other substances)

Surgeries

DATE Reason None ☐

Illnesses

None ☐

(List any chronic or recurrent illnesses - date of onset)

Accidents/injuries

DATE (please list) None ☐

List All Medications You Take Regularly Prescription and Non-prescription

Medicine Dose None ☐

Reason for Today's visit

☑ **Please check any that you have had or now have:**

- ☐ Abnormal Pap Smear
- ☐ AIDS or HIV Disease
- ☐ Alcohol Overuse or Abuse
- ☐ Allergies or Hay Fever
- ☐ Anemia (i.e. -low iron)
- ☐ Anxiety or Panic Attacks
- ☐ Arthritis or Gout
- ☐ Asthma
- ☐ Back Problems
- ☐ Bladder infections
- ☐ Blood Clots or Bleeding Prob.
- ☐ Blood Transfusion
- ☐ Boils or Cysts- recurrent
- ☐ Bone or Joint Disease
- ☐ Bowel or Colon Disease
- ☐ Broken or cracked bones
- ☐ Breast Lumps
- ☐ Bronchitis - recurrent
- ☐ Bursitis or Tendonitis
- ☐ Cancer
- ☐ Cholesterol - elevated
- ☐ Colitis
- ☐ Concussion or Head Injury
- ☐ Depression
- ☐ Suicide Attempt
- ☐ Diabetes
- ☐ Drug Overuse or Abuse
- ☐ Emphysema
- ☐ Excessive Stress
- ☐ Gallbladder Disease or Gallstone
- ☐ Glaucoma
- ☐ Gonorrhea, Syphilis, Chlamydia, or HPV
- ☐ Headaches - Severe
- ☐ Hearing Problem
- ☐ Heart Attack
- ☐ Heart Murmur or Heart Disease
- ☐ Hepatitis or Cirrhosis
- ☐ Herniated or Ruptured Disc
- ☐ Herpes - genital
- ☐ High Blood Pressure
- ☐ Hodgkin's Disease, Lymphoma or Leukemia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Stones
- ☐ Liver Problems
- ☐ Lupus
- ☐ Malaria
- ☐ Meningitis
- ☐ Migraine Headache
- ☐ Muscle Disease or Weakness
- ☐ Nervous Breakdown
- ☐ Pancreatitis
- ☐ Phlebitis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ *Rheumatoid* Arthritis
- ☐ Rheumatoid Fever
- ☐ Seizures, Convulsions, or Epilepsy
- ☐ Sexually Transmitted Disease
- ☐ Sickle Cell Disease or Trait
- ☐ Skin Disease - Chronic
- ☐ Skin Infections - Recurrent
- ☐ Sleep Difficulties or Disorders
- ☐ Sprains or Dislocations - Severe
- ☐ Stroke or Brain Attack
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB) or positive test
- ☐ Ulcer Disease or Gastritis
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Vision Problem
- ☐ Yellow jaundice
- ☐ **Other**

Aaron C. Polk, Jr., M.D.
Carl A. Davis, M.D.
212 Russell Blvd.
Nacogdoches, TX 75965

ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notices of Privacy Practices, which explains how my medical information will be used and disclosed. I have been given an opportunity to ask questions if I do not understand.

I understand that I am entitled to receive a copy of this document.

_____
Initial

PHARMACY QUERY PERMISSION

By signing below, I give the offices of Dr. Aaron C. Polk, Jr. and Dr. Carl A. Davis permission to query all medications prescribed to me from the online pharmacy database.

_____
Initial

_____
Signature of Patient or Personal Representative

_____ _____
Printed Name of Patient Date of Birth

_____
Date