Weekend

Bellingham Walk–in Clinic

New Patient Registration Form

Name:_____

Address:_____ Apt # _____

City_____ State_____ Zip Code _____

Date of Birth: _____ Marital Status M W D S

Home Phone :_____ Work Phone:_____

Cell Phone:_____ Preferred Contact: □ Home □ Work □ Cell

E-mail Address:_____

Employed by: _____ Occupation: _____

Preferred Pharmacy_____ SSN#_____-_____-_____

Emergency Contact:_____ Phone #_____

Primary Insurance Company _____

Policy Holder Name _____

Policy Holder Date of Birth:_____Policy Holder Social Sec No:_____-_____-_____

Policy Holder Address_____

Primary Insurance ID No_____

Secondary Insurance Company_____

Secondary Insurance ID No_____

How did you hear about us ?_____

By signing below, I authorize the Bellingham Walk-in Clinic or its agents to furnish to any hospital, health care service plan, or insurer any medical information obtained if such disclosure is necessary to allow the processing of any insurance claims. I have been given the opportunity to examine the "Notice of Privacy Practice" and "Notice of Patients Rights" if I so desire. I acknowledge that I am financially responsible for any co-payments, deductibles or denials of payment by my insurance company. I authorize the charging of any co-pay or insurance mandated deductible due to my credit card on file at the office.

Signature: _____ Date _____

PRESENT HEALTH CONCERNS: _____

_____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose (eg. mg/pill)	How many times per day	When started

ALLERGIES or REACTIONS TO MEDICINES: _____

When were your most recent **IMMUNIZATIONS:**

Hepatitis A ____ Hepatitis B ____ Influenza (Flu Shot) ____ Measles ____ Pneumovax (Pneumonia) ____
Rubella _____ Tetanus (Td) ___ Varicella (chicken pox) shot_____ or Illness ____

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with dates):

___ Heart disease:
specify type _____
___ Heart attack (412)
___ High blood pressure (401.9)
___ Diabetes (Endo, 250.00)
___ High cholesterol (Endo, 272.4)
___ Thyroid problem (246.9)
specify type _____

___ Bleeding/clotting problem (286.9)
___ Blood transfusion (V58.2)
___ Cancer (Malignancy)
specify type _____
___ Stroke
___ Depression/suicide attempt (311)

___ Alcoholism (Sub, 303.90)

Other problems (specify):
_____
_____
_____

SURGICAL HISTORY:

Please list all prior operations (with dates): _____

_____

SOCIAL HISTORY

Substance & Sexuality

Tobacco Use

Cigarettes ❑ Never ❑ Quit: Date _____
❑ Current: Smoker: packs/day _____ # of yrs _____

Other Tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Ch
Are you interested in quitting? ❑ No ❑ Yes

Alcohol Use

Do you drink alcohol? ❑ No ❑ Yes: # drinks/week ____
Is alcohol use a concern for you or others? ❑ No ❑ Yes

Drug Use

Do you use any recreational drugs? ❑ No ❑ Yes
Have you ever used needles? ❑ No ❑ Yes

REVIEW OF SYMPTOMS: Please check (✔) any current problems you have on the list below:

Constitutional
___ Fevers/chills/sweats
___ Unexplained weight loss/gain
___ Change in energy/weakness
___ Excessive thirst or urination

Eyes
___ Change in vision

Ears/Nose/Throat/Mouth
___ Difficult hearing/ringing in ears
___ Problems with teeth/gums
___ Hay fever/allergies

Cardiovascular
___ Chest pain/discomfort
___ Palpitations

Respiratory
___ Cough/wheeze
___ Difficulty breathing

Gastrointestinal
___ Abdominal pain
___ Blood in bowel movement
___ Nausea/vomiting/diarrhea

Genitourinary
___ Nighttime urination
___ Leaking urine
___ Unusual vaginal bleeding
___ Discharge: penis or vagina

Musculo-skeletal
___ Muscle/joint pain

Neurological
___ Headaches
___ Dizziness/light-headedness
___ Numbness
___ Memory loss
___ Loss of coordination

Psychiatric
___ Anxiety/stress
___ Problems with sleep
___ Depression

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/bleeding

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor