

**PATIENT REGISTRATION FORM**

Please complete form using your legal name as it appears on your social security card.

Date: \_\_\_\_\_ Email Address: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed SSN: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt# \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employment Status:  Full-Time  Part-Time  Retired  Unemployed  Disabled  Self Employed

Employer Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Husband's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Husband's SSN: \_\_\_\_\_ Husband's Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referred By:  Physician  Friend  Other

**Insurance: Please allow us to make a copy of your insurance card(s) and provide us with all pertinent information regarding your insurance coverage.**

Primary insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**If it is necessary for me to bring my child at the time of my visit, I understand that it is my responsibility to watch out for the safety and well being of my child.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# JEFFREY B. BROWN, MD

## Patient Information and History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age of your first period: \_\_\_\_ Cycle length in days: \_\_\_\_ How many days does your period last? \_\_\_\_

If using birth control, which method?  Birth control pills  Foam  Condoms  IUD  Depo-provera  
 Diaphragm  Tubal Ligation  Vasectomy  Withdrawal

Have you ever had an abnormal Pap smear?  No  Yes, Date: \_\_\_\_\_ Treatment \_\_\_\_\_

Do you do self breast exam?  Never  Sometimes  Monthly Date of last mammogram: \_\_\_\_\_

If age 50 or older, have you had:

A sigmoidoscopy or colonoscopy in the past five years?  Yes  No

A bone density test (test for osteoporosis)?  Yes  No

### Operations/Hospitalizations

Operation/Hospitalization	Date	Name of Hospital/Doctor

### Obstetric History

		Number			Number			Number
Pregnancies:			Live Births:			Miscarriages:		
Living Children:			Premature:			Abortions:		
No.	Birth date	Birth Weight	Baby's Sex	Weeks Pregnant	Type of Delivery	Complications?		
1								
2								
3								
4								
5								
6								

### Personal Past History of Illness

Major Illness	Yes	No	Major Illness	Yes	No	Major Illness	Yes	No
Asthma			Stroke			Blood transfusions		
Kidney Stones			Rheumatic Fever			Seizures / Epilepsy		
Kidney Infection			Blood clots lungs/legs			Bowel problems		
Tuberculosis			Eating disorder			IBS/Spastic colon		
STD's			Lupus			Hepatitis/liver disease		
HIV/AIDS			Cancer			Thyroid disease		
Heart trouble			Ulcer, reflux, hernia			Gallbladder problems		
Diabetes			Depression/anxiety					
High blood pressure			Anemia					

**JEFFREY B. BROWN MD**  
**PATIENT INFORMATION & HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Current Medications**

(including hormones, vitamins, herbs, non-prescription and diet medications)

Drug Name	Dosage	Medical Problem	Drug Name	Dosage	Medical Problem

**Drug Allergies**

Check Here If No Known Drug Allergies

Drug	What happens when you take it?

**Review of Systems**  
**Mark (x) all that apply**

<p><b>1. Constitutional</b></p> <p><input type="checkbox"/> Recent weight loss/gain</p> <p><input type="checkbox"/> Fatigue</p> <p><b>2. Ears, Nose, Throat</b></p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Mouth sores</p> <p><b>3. Cardiovascular</b></p> <p><input type="checkbox"/> Swelling of feet or legs</p> <p><input type="checkbox"/> Rapid or irregular heart beat</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> Varicose veins</p> <p><b>4. Gastrointestinal</b></p> <p><input type="checkbox"/> Frequent diarrhea</p> <p><input type="checkbox"/> Bloody stool/rectal bleeding</p> <p><input type="checkbox"/> Nausea/vomiting</p> <p><input type="checkbox"/> Constipation</p>	<p><b>5. Genitourinary</b></p> <p><input type="checkbox"/> Abnormal bleeding</p> <p><input type="checkbox"/> Painful Periods</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Abnormal vaginal discharge</p> <p><input type="checkbox"/> Difficulty becoming pregnant</p> <p><input type="checkbox"/> PMS</p> <p><input type="checkbox"/> DES exposure</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Pain with urination</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Involuntary loss of urine</p> <p><input type="checkbox"/> Pelvic pain</p> <p><b>6a. Skin</b></p> <p><input type="checkbox"/> Unwanted hair</p> <p><input type="checkbox"/> Black or enlarged moles</p> <p><input type="checkbox"/> Rash or itching</p> <p><b>6b. Breasts</b></p> <p><input type="checkbox"/> Pain in breasts</p> <p><input type="checkbox"/> Nipple discharge</p> <p><input type="checkbox"/> Lumps</p>	<p><b>7. Neurologic</b></p> <p><input type="checkbox"/> Dizziness or light-headedness</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Frequent or severe headaches</p> <p><b>8. Psychiatric</b></p> <p><input type="checkbox"/> Depression or crying episodes</p> <p><input type="checkbox"/> Sleep problems</p> <p><input type="checkbox"/> Panic attacks/anxiety</p> <p><b>9. Endocrine</b></p> <p><input type="checkbox"/> Glandular / Hormone problems</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Abnormal thirst or urination</p> <p><input type="checkbox"/> Hot flashes</p> <p><b>10. Lymphatic</b></p> <p><input type="checkbox"/> Enlarged lymph nodes</p>
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## JEFFREY B. BROWN, MD

### Patient Information and History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

#### Family History

Major Illness	Yes	No	Physician Notes	Major Illness	Yes	No	Physician Notes
Heart disease				Ovarian cancer			
High cholesterol				Colon cancer			
Hypertension				Other cancer			
Diabetes							
Osteoporosis							
Breast cancer							

#### Social History

	Yes	No		Yes	No
Do you smoke? Packs per day ___ yrs ___			Seat belt use		
Ex-smoker? Packs per day ___ yrs ___			Regular exercise		
Use alcohol? Drinks per week ___ yrs ___			Take calcium supplement		
Recreational drug use			Sexually abused or hurt by someone		



One Time Authorization Form

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named facility all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I, and not the insurance company, am responsible for the payment of all services.

INITIAL: \_\_\_\_\_

Responsibility for copay amounts: I agree to be fully responsible for paying co-pays of set amounts at the time of physician's visit. Further, I understand that if my copay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received, once insurance has paid, will be due upon receipt.

INITIAL: \_\_\_\_\_

Assumption of referrals: I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician, it must be received in order to receive the maximum benefits from the insurance company, I further understand that it is my responsibility to obtain a hard copy referral from my Primary Care Physician, I have been given the opportunity by the above said provider to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

INITIAL: \_\_\_\_\_

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits, including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of as third party or organization, and so forth, payable to or for the above said patient until account is paid in full.

INITIAL: \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Acknowledgement of Receipt of Privacy Notice.- I acknowledge receiving today a copy of the provider's notice of privacy Policies- I consent to the provider's use of protected health information as described in the notice for treatment, payment, of health care operations- I understand that I must provide a separate authorization before any other disclosures may be made.

INITIAL: \_\_\_\_\_

Rem Reminder / notification: We may call you to remind you of your appointment or notify you of test results. I agree, if I have an answering machine, to allow the doctor or staff members to identify themselves, as well as myself and to notify me of my appointment or tell me that test results are back. We will not leave test results on your answering machine.

INITIAL: \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Request for restrictions: I request that my protected health information be disclosed to the following persons or facility (please list): \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_