

Healthcare Centers of Morris Hospital Registration Form

Please complete front and back

Date: _____ PCP: _____

Last Name: _____ **First Name:** _____ **MI:** _____

Is this your legal name? Yes No If not, what is your legal name? _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Email Address: _____

Date of Birth: ____/____/____ **Sex:** M F **Social Security Number:** ____-____-____

Marital Status: Single Married Widowed Separated Divorced Partner

Preferred Language: English Spanish Russian Other

Race: White Black/African American Hispanic Asian Native Hawaiian
 American Indian/Alaska Native Other Refused to Report

Ethnicity: Hispanic Non-Hispanic Refused to Report

Employer: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Employment Status: FT PT Not Employed **Are you a Student?** If yes, FT PT

Preferred Pharmacy: _____ Pharmacy Phone #: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Release test results only to me

Leave message on voicemail to call the office

Leave message on voicemail with test results

Leave message or test results with family member

Specify Name: _____ **Phone:** (____) _____

I have a legal document indicating a Medical Power of Attorney, Living Will, and/or DNR status (*if yes, please provide the office with a copy for your records*)

Medical Power of Attorney Do Not Resuscitate Living Will Not applicable None

Emergency Contact

Last Name: _____ **First Name:** _____ **MI:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: _____ Relationship to Patient: _____

Can medical information be released to this person? Yes No

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Responsible Party *(person responsible for bill)*

Same as Patient

Last Name: _____ **First Name:** _____ **MI:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Relationship to Patient: _____

Date of Birth: ____/____/____ Sex: M F Social Security Number: ____ - ____ - ____

Employer Name: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance Company: _____

Subscriber #: _____ Group #: _____

Subscriber Name: _____ Same as Patient

Is this person a patient here? Yes No

Date of Birth: ____/____/____ Relationship to Patient _____ SSN#: _____

Name of Employer: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Company: _____

Subscriber #: _____ Group #: _____

Subscriber Name: _____ Same as Patient

Is this person a patient here? Yes No

Date of Birth: ____/____/____ Relationship to Patient _____ SSN#: _____

Name of Employer: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Tertiary Insurance Company: _____

Subscriber #: _____ Group #: _____

Subscriber Name: _____ Same as Patient

Is this person a patient here? Yes No

Date of Birth: ____/____/____ Relationship to Patient _____ SSN#: _____

Name of Employer: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____



Healthcare Centers of Morris Hospital

MEDICAL & FAMILY HISTORY FORM

NAME: _____ **DATE OF BIRTH:** _____ **TODAY'S DATE:** _____

Medications — Please list all of your current prescription and non-prescription medications, vitamins and supplements:

None

Medication	Strength	Frequency

Past Medical History None

- | | | | | |
|--------------------------------------------|----------------------------------------------|---------------------------------------------------|----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Depression | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Stroke or paralysis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney disease/failure | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> TB skin test positive |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fatty liver | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal disease |
| Type: _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Polio | Other _____ |
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Lupus | <input type="checkbox"/> Psoriasis | |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Measles | <input type="checkbox"/> Radiation therapy | |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sciatica | |
| <input type="checkbox"/> Colon polyps | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Milk intolerance | <input type="checkbox"/> Seizures | |

Allergies (List all known allergies, including medication, food, animals, seasonal, etc.) None

Allergy	Reaction	Allergy	Reaction

Surgeries/Procedures

- | | | | | | |
|----------------------------------------|------------------------------------|---------------------------------------|-----------------------------------------------|------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hemorrhoid surgery | <input type="checkbox"/> Liver biopsy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> C-section | <input type="checkbox"/> Groin hernia | <input type="checkbox"/> Hiatal hernia repair | <input type="checkbox"/> Obesity surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Ovary | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Colon surgery | <input type="checkbox"/> EGD | <input type="checkbox"/> Heart stent | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Uterus |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> ERCP | <input type="checkbox"/> Heart valve | <input type="checkbox"/> Kidney | <input type="checkbox"/> Stomach | Other: _____ |

Previous Hospitalizations None

Reason	Date	Reason	Date

Family History

	Father	Mother	Grandparents	Siblings	Children
Healthy/Alive	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Deceased	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Colon polyps	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Colon cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Ulcer disease	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Pancreas disease	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Chrohn's disease	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Ulcerative colitis	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Stomach cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes mellitus	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart attack	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Breast cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Other cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
High cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Social History

- Daycare: no yes
 - Smoke detector use: no yes
 - Alcohol use no yes; amount per day: _____ for _____ years
 - Caffeine: no yes
 - Exercise no yes; how much and how often: _____
 - Living with: spouse children siblings parents mother father
 - Marital status married single divorced widowed
 - Occupation: _____ unemployed retired
 - Pets: no yes
 - Drug use no yes; specify drugs and amounts: _____
 - Tobacco Use: never current former exposure to second-hand smoke smokers in home
- If current, how often?
- every day some days, but not every day
- If current, how many a day?
- 5 or less 6-10 11-20 21-30 31 or more
- If current, how soon after you wake?
- within 5 min 6-30 min 31-60 min after 60 min
- If current, are you interested in quitting?
- ready to quit thinking about quitting not ready to quit
- If former, how long has it been since you smoked?
- < a month 1-3 months 3-6 months 6-12 months 1-5 years 5-10 years > 10 years