HEALTHCARE CENTERS
*of* MORRIS HOSPITAL

## Morris Hospital and Healthcare Centers Registration Form

**Patient Information**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Last Name:** | **First Name:** | | **M.I.:** | **Suffix:** | **Prefix:** | **Maiden/Previous Name (if applicable):** | |
| **Date of Birth:** | **Birth Sex:** | **Legal Sex:** | **Social Security Number:** | | **Primary Care Provider:** | **Referring Provider:** | |
| **Home Phone Number:** | **Cell Phone Number:** | | **Work Number:** | | **Preferred Number:** ☐ Home ☐ Cell ☐ Work | | |
| **Address:** | **City:** | **State:** | **Zip:** | **Email:** | | | |

| | | | | |
|---|---|---|---|---|
| **Preferred Language (please select one):**<br>☐ English<br>☐ Spanish<br>☐ Decline to Specify<br>☐ Other: _____ | **Interpretor needed:**<br>☐ Yes ☐ No<br>**if a translator is needed, one will be provided.* | **Marital Status:**<br>☐ Married<br>☐ Divorced<br>☐ Partner<br>☐ Single<br>☐ Widowed<br>☐ Legally Separated | **Race (please select one):**<br>☐ American Indian or Alaska Native<br>☐ Asian<br>☐ Native Hawaiian or Other Pacific Islander<br>☐ Black or African American<br>☐ White<br>☐ Decline to Specify<br>☐ Other _____ | **Ethnicity (please select one):**<br>☐ Hispanic/Latino<br>☐ Not Hispanic or Latino<br>☐ Decline to Specify |

| | | |
|---|---|---|
| **Preferred Name:** | **Employment Status:**<br>☐ Full-Time ☐Part-Time ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Other: _____ | |
| **Employer Name:** | **Employer Address:** | **Employer Phone #:** |
| **Advanced Directives:** (*If yes, please provide the office with a copy for your record*)<br>Living Will ☐ Yes ☐ No Resuscitation Status: _____<br>Power of Attorney ☐ Yes ☐ No<br>Power of Attorney Name and Number:_____ | | **Preferred Pharmacy Name and Location: (please include any mail order pharmacy)** |

**Primary Insurance**

| | | | | | |
|---|---|---|---|---|---|
| **Primary Insurance Company:** | | | | | |
| **Subscriber Last Name:** | **Subscriber First Name:** | **M.I.:** | **Prefix:** | **Suffix:** | **Relationship to Patient:** |
| **Name on card (if different):** | **Subscriber DOB:** | **Birth Sex:** | **Legal Sex:** | **Social Security Number:** | |

| | | | |
|---|---|---|---|
| **Marital Status:**<br>☐ Married<br>☐ Divorced<br>☐ Partner<br>☐ Single<br>☐ Widowed<br>☐ Legally Separated | **Race (please select one):**<br>☐ American Indian or Alaska Native<br>☐ Asian<br>☐ Native Hawaiian or Other Pacific Islander<br>☐ Black or African American<br>☐ White<br>☐ Decline to Specify<br>☐ Other _____ | **Preferred Language (please select one):**<br>☐ English<br>☐ Spanish<br>☐ Decline to Specify<br>☐ Other: _____ | **Citizenship:**<br>☐ Yes ☐ No |

| | | | | | |
|---|---|---|---|---|---|
| **Email:** | **Subscriber Address**: ☐ Same as Patient | **City:** | | **State:** | **Zip:** |
| **Home Phone:** | **Cell Phone:** | **Work Phone:** | **Policy ID:** | **Coverage Plan:** | |
| **Group Name:** | **Group Number:** | **Employment Status:** | **Employer Name:** | **Employer Location:** | |

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**Secondary Insurance**

| | | | | | |
|---|---|---|---|---|---|
| **Secondary Insurance Company:** | | | | | |
| **Subscriber Last Name:** | **Subscriber First Name:** | **M.I.:** | **Prefix:** | **Suffix:** | **Relationship to Patient:** |
| **Name on card (if different):** | **Subscriber DOB:** | **Birth Sex:** | **Legal Sex:** | **Social Security Number:** | |
| **Marital Status:**<br>☐ Married<br>☐ Divorced<br>☐ Partner<br>☐ Single<br>☐ Widowed<br>☐ Legally Separated | **Race (please select one):**<br>☐ American Indian or Alaska Native<br>☐ Asian<br>☐ Native Hawaiian or Other Pacific Islander<br>☐ Black or African American<br>☐ White<br>☐ Decline to Specify<br>☐ Other _____ | | **Preferred Language (please select one):**<br>☐ English<br>☐ Spanish<br>☐ Decline to Specify<br>☐ Other: _____ | **Citizenship:**<br>☐ Yes ☐ No | |
| **Email:** | **Subscriber Address**: ☐ Same as Patient | | **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Cell Phone:** | **Work Phone:** | **Policy ID:** | **Coverage Plan:** | |
| **Group Name:** | **Group Number:** | **Employment Status:** | **Employer Name:** | **Employer Location:** | |

**Tertiary Insurance**

| | | | | | |
|---|---|---|---|---|---|
| **Tertiary Insurance Company:** | | | | | |
| **Subscriber Last Name:** | **Subscriber First Name:** | **M.I.:** | **Prefix:** | **Suffix:** | **Relationship to Patient:** |
| **Name on card (if different):** | **Subscriber DOB:** | **Birth Sex:** | **Legal Sex:** | **Social Security Number:** | |
| **Marital Status:**<br>☐ Married<br>☐ Divorced<br>☐ Partner<br>☐ Single<br>☐ Widowed<br>☐ Legally Separated | **Race (please select one):**<br>☐ American Indian or Alaska Native<br>☐ Asian<br>☐ Native Hawaiian or Other Pacific Islander<br>☐ Black or African American<br>☐ White<br>☐ Decline to Specify<br>☐ Other _____ | | **Preferred Language (please select one):**<br>☐ English<br>☐ Spanish<br>☐ Decline to Specify<br>☐ Other: _____ | **Citizenship:**<br>☐ Yes ☐ No | |
| **Email:** | **Subscriber Address**: ☐ Same as Patient | | **City:** | **State:** | **Zip:** |
| **Home Phone:** | **Cell Phone:** | **Work Phone:** | **Policy ID:** | **Coverage Plan:** | |
| **Group Name:** | **Group Number:** | **Employment Status:** | **Employer Name:** | **Employer Location:** | |

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| | | | |
|---|---|---|---|
| **Primary** | ***Primary Emergency Contact*** | | |
| | **Last Name:** | **First Name:** | **Relationship to Patient:** |
| | **Home Phone Number:** | **Cell Phone Number:** | **Work Phone Number:** |
| **Secondary** | ***Secondary Emergency Contact*** | | |
| | **Last Name:** | **First Name:** | **Relationship to Patient:** |
| | **Home Phone Number:** | **Cell Phone Number:** | **Work Phone Number:** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Responsible Party/Guarantor** | *****Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor and is responsible for the bill. Statements will be sent to the responsible party listed. ***** | | | | | |
| | **Guarantor Last Name:** | **Guarantor First Name:** | **M.I.:** | | **Prefix:** | **Suffix:** |
| | **Relationship:** | **Guarantor DOB:** | **Birth Sex:** | **Legal Sex:** | **Social Security Number:** | **Language:** |
| | **Email:** | **Address**: ☐ Same as Patient | | **City:** | **State:** | **Zip:** |
| | **Home Phone:** | **Cell Phone:** | | **Work Phone:** | | |
| | **Employer Name:** | **Employer Address:** | **Employer City:** | | **Employer State:** | **Employer Zip:** |
| | **Employer Phone:** | **Employer Fax:** | **Employer Email:** | | **Occupation:** | **Employment Status:** |

**Initials:**

_____ I understand that it is the policy of the Healthcare Centers of Morris Hospital to be given at least 24 hour notice when canceling an appointment. I understand that more than 3 failures to cancel appointments without proper notice may result in being discharged from the practice.

_____ This Healthcare Center is a lab drawing station for Morris Hospital and all labs will be processed by the Morris Hospital laboratory. I am aware that my insurance may prefer or require an outside lab to be used for lab processing and that I am responsible for the charges that my insurance does not pay.

_____ I have read and been offered a current copy of the Notice of Privacy Practices.

_____ I have read and been offered a current copy of the Patient Rights and Responsibilities.

_____ I understand that my medication history will be verified electronically for treatment purposes.

_____ I understand that my immunization records will be sent electronically to the State of Illinois Immunization Registry.

_____ _____

**Patient or Parent/Guardian Signature** **Date**

***By signing I attest to all information provided is true to the best of my knowledge.**

HEALTHCARE CENTERS of MORRIS HOSPITAL

# MEDICAL & FAMILY HISTORY FORM

Name: _____ DOB: _____

| Other Medical Providers | Specialty | Phone # / Location |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**ALLERGIES** (List all known allergies, including medication, food, animals, seasonal, etc.)

☐ None

Do you have a **latex** allergy? ☐ Yes ☐ No

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |

**MEDICATIONS** Please list all of your current prescription and non-prescription medications, vitamins and supplements:

☐ None

| Medication | Strength | Frequency | When did you start medication? |
|---|---|---|---|
| | | | |
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HEALTHCARE CENTERS of MORRIS HOSPITAL

## PAST MEDICAL HISTORY:

**Birth History: (***Pediatric patients only***)**

Birth weight: _____ Delivering Physician/Hospital: _____

☐Full-Term (>38 weeks) ☐ Vaginal ☐ C-Section due to _____

☐Premature (<38 weeks) # weeks _____ ☐ Forceps ☐ Vacuum

Pregnancy Concerns: _____ ☐ None Newborn Concerns: _____ ☐ Jaundice ☐ None

## PAST MEDICAL HISTORY:

☐ None

- ☐ Acid reflux
- ☐ Alcohol abuse
- ☐ ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Bedwetting
- ☐ Bi-pap/C-pap use
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Breast problem
- ☐ Cancer, Type:_____
- ☐ Chest Pain/Angina
- ☐ Chicken pox
- ☐ Cough
- ☐ Coronary Artery Disease /CAD
- ☐ Cirrhosis
- ☐ Colon Polyps
- ☐ Constipation
- ☐ Crohn's disease
- ☐ Congestive Heart failure/ CHF
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug Abuse
- ☐ Ear infections, multiple
- ☐ Emphysema
- ☐ Eczema
- ☐ Fatty liver
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High triglycerides
- ☐ HIV or AIDS
- ☐ Irregular Heart Beat
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease /failure
- ☐ Lung Disease
- ☐ Lupus
- ☐ Measles
- ☐ Memory problems
- ☐ Migraines
- ☐ Milk intolerance
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Ovarian cyst
- ☐ Overweight
- ☐ Pancreatitis
- ☐ Parkinsons Disease
- ☐ Peptic Ulcer
- ☐ Peripheral Vascular Disease /PVD
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Pyloric stenosis
- ☐ Radiation therapy
- ☐ Rheumatic fever
- ☐ RSV
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sexual problems
- ☐ Sinusitis
- ☐ Sleep apnea
- ☐ Strep throat, multiple
- ☐ Stomach ulcer
- ☐ Stroke or paralysis
- ☐ TB – Tuberculosis
- ☐ TB skin test positive
- ☐ Thyroid disease
- ☐ Ulcerative colitis
- ☐ Urinary reflux
- ☐ Varicose veins
- ☐ Venereal disease
- ☐ Other_____

## SURGERIES/PROCEDURES

- ☐ None
- ☐ Appendectomy
- ☐ Breast
- ☐ Colon surgery
- ☐ Colonoscopy
- ☐ Colostomy
- ☐ C-section
- ☐ Defibrillator /Heart pacemaker
- ☐ Ear tubes
- ☐ EGD
- ☐ ERCP
- ☐ Gallbladder
- ☐ Groin hernia
- ☐ Heart bypass
- ☐ Heart stent
- ☐ Heart valve
- ☐ Hemorrhoid surgery
- ☐ Hiatal hernia
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Kidney
- ☐ Mastectomy
- ☐ Liver biopsy
- ☐ Obesity surgery/Gastric bypass
- ☐ Ovary
- ☐ Prostate
- ☐ Stomach
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Tubal ligation
- ☐ Uterus
- ☐ Other_____

## PREVIOUS HOSPITALIZATIONS OR SERIOUS INJURIES

☐ None

| Hospitalization or Injury | Date |
|---|---|
| | |
| | |
| | |

## IMMUNIZATIONS

**Pediatric Immunizations** ☐ UNKNOWN Immunization history ☐ Immunization records available

**Adult Immunizations/Vaccination Records** ☐ UNKNOWN Immunization history

| Check if received | Vaccination / Immunization | Date Received |
|---|---|---|
| ☐ | Influenza /Flu | |
| ☐ | Pneumonia | |
| ☐ | Tetanus | |
| ☐ | Shingles | |
| ☐ | Other - | |
| ☐ | Other - | |

## FAMILY HISTORY (Check the appropriate box to indicate which relative has had the following diseases)

| Parents / Grandparents | Father | Mother | Paternal Grandfather | Paternal Grandmother | Maternal Grandfather | Maternal Grandmother |
|---|---|---|---|---|---|---|
| | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased |
| NO KNOWN HEALTH ISSUES | | | | | | |
| Diabetes | | | | | | |
| High Blood Pressure | | | | | | |
| Heart Disease | | | | | | |
| Cancer | | | | | | |
| | Type: | Type: | Type: | Type: | Type: | Type: |
| Arthritis | | | | | | |
| Endometriosis | | | | | | |
| Heart Attack | | | | | | |
| High Cholesterol | | | | | | |
| Lupus | | | | | | |
| Osteoporosis | | | | | | |
| Thyroid Disease | | | | | | |
| Lung | | | | | | |
| Bowel | | | | | | |
| Gallbladder | | | | | | |
| Other: please specify | | | | | | |
| Unknown history | | | | | | |

| **Brothers / Sisters** | ☐Brother ☐Sister | ☐Brother ☐Sister | ☐Brother ☐Sister | ☐Brother ☐Sister | ☐Brother ☐Sister | ☐Brother ☐Sister |
|---|---|---|---|---|---|---|
| | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased |
| NO KNOWN HEALTH ISSUES | | | | | | |
| Diabetes | | | | | | |
| High Blood Pressure | | | | | | |
| Heart Disease | | | | | | |
| Cancer | | | | | | |
| | Type: | Type: | Type: | Type: | Type: | Type: |
| Arthritis | | | | | | |
| Endometriosis | | | | | | |
| Heart Attack | | | | | | |
| High Cholesterol | | | | | | |
| Lupus | | | | | | |
| Osteoporosis | | | | | | |
| Thyroid Disease | | | | | | |
| Lung | | | | | | |
| Bowel | | | | | | |
| Gallbladder | | | | | | |
| Other: please specify | | | | | | |
| Unknown history | | | | | | |

| **# Sons _____**<br>**# Daughters _____** | ☐Son ☐Daughter | ☐Son ☐Daughter | ☐Son ☐Daughter | ☐Son ☐Daughter | ☐Son ☐Daughter | ☐Son ☐Daughter |
|---|---|---|---|---|---|---|
| | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased | ☐Alive ☐Deceased |
| NO KNOWN HEALTH ISSUES | | | | | | |
| Diabetes | | | | | | |
| High Blood Pressure | | | | | | |
| Heart Disease | | | | | | |
| Cancer | | | | | | |
| | Type: | Type: | Type: | Type: | Type: | Type: |
| Arthritis | | | | | | |
| Endometriosis | | | | | | |
| Heart Attack | | | | | | |
| High Cholesterol | | | | | | |
| Lupus | | | | | | |
| Osteoporosis | | | | | | |
| Thyroid Disease | | | | | | |
| Lung | | | | | | |
| Bowel | | | | | | |
| Gallbladder | | | | | | |
| Other: please specify | | | | | | |
| Unknown history | | | | | | |

HEALTHCARE CENTERS of MORRIS HOSPITAL

## SOCIAL HISTORY

| | |
|---|---|
| **Tobacco Use Screening:** | ☐ Never ☐ Current, Daily Smoker ☐ Current, Some Days Smoker ☐ Former Smoker<br>*If current or former, what tobacco products do you use?*<br>☐ Cigarettes ☐ Cigars ☐ Pipe<br>*If current or former cigarette smoker, how many cigarettes a day?*<br>☐ number of packs per day _____ OR ☐ number of cigarettes per day _____<br>*If current or former cigarette smoker, date/year started smoking* _____<br>*If former cigarette smoker, date/year quit smoking* _____<br>*If current or former cigarette smoker, number of years smoked* _____<br>*If former cigarette smoker, how long has it been since you smoked?*<br>☐ less than 15 yrs ago ☐ more than 15 years ago<br>*If current daily smoker, are you interested in quitting?*<br>☐ Ready to Quit ☐ Thinking About Quitting ☐ Not Ready to Quit<br>Do you use any of these nicotine containing products?<br>☐ E-Cigarettes ☐ Vaping Products ☐ Smokeless Tobacco ☐ Other: _____<br>*If you use smokeless tobacco, what product?*<br>☐ chewing tobacco ☐ Snuff ☐ snus ☐ dissolvable tobacco ☐ Other: _____<br>Do you have exposure to second hand tobacco smoke?<br>☐ Yes ☐ No |
| **Alcohol Use Screening:** | *Within the past year, how often did you have a drink containing alcohol?* ☐ Never<br>☐ Monthly or Less ☐ 2-4 Times a Month ☐ 2-3 Times a Week ☐ 4 or More Times a Week<br>*Within the past year, how many standard drinks containing alcohol did you have on a typical day?*<br>☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more<br>*Within the past year, how often did you have six or more drinks on one occasion?*<br>☐ Never ☐ Less Than Monthly ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily |
| **Recreational Drug Use:** | ☐ No ☐ Former ☐ Cannabis (any form) ☐ Cocaine ☐ Amphetamines/Methamphetamines<br>☐ Sedatives/Tranquiliers ☐ Opioids/Painkillers ☐ Club/Designer Drugs ☐ Other: _____ |
| **Occupation:** | _____ ☐ Unemployed ☐ Retired |
| **Education Level:** | Highest grade level completed:<br>☐ Pre-School ☐ Grade School ☐ Home School ☐ High School ☐ College ☐ Other: _____ |
| **Pets:** | ☐ No ☐ Yes - Type: _____ |
| **Marital Status:** | ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Married ☐ Single ☐ Widow/Widower<br>☐ Other: _____ |
| **Living with:** | ☐ Alone ☐ Assisted Living ☐ Foster Family ☐ Grandparents ☐ Group Home ☐ Homeless<br>☐ Institution ☐ Intermediate Care Facility ☐ Live-In Caregiver ☐ Senior House<br>☐ Significant Other ☐ Skilled Nursing Facility ☐ With Children ☐ With Others: _____<br>☐ With Parent ☐ With Spouse |
| **Health Literacy:** | Do you feel comfortable filling in medical forms? ☐ Yes ☐ No |
| **Special Considerations (Notes):** | Any other special considerations pertaining to medical care? ☐ No ☐ Yes<br>If yes, explain _____ |