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

Preferred Name:	**Employment Status:** ☐ 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*) Living Will ☐ Yes ☐ No Resuscitation Status: _____ Power of Attorney ☐ Yes ☐ No 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: ☐ Married ☐ Divorced ☐ Partner ☐ Single ☐ Widowed ☐ Legally Separated	**Race (please select one):** ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Decline to Specify ☐ Other _____	**Preferred Language (please select one):** ☐ English ☐ Spanish ☐ Decline to Specify ☐ Other: _____	**Citizenship:** ☐ 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: ☐ Married ☐ Divorced ☐ Partner ☐ Single ☐ Widowed ☐ Legally Separated	**Race (please select one):** ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Decline to Specify ☐ Other _____		**Preferred Language (please select one):** ☐ English ☐ Spanish ☐ Decline to Specify ☐ Other: _____	**Citizenship:** ☐ 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: ☐ Married ☐ Divorced ☐ Partner ☐ Single ☐ Widowed ☐ Legally Separated	**Race (please select one):** ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Decline to Specify ☐ Other _____		**Preferred Language (please select one):** ☐ English ☐ Spanish ☐ Decline to Specify ☐ Other: _____	**Citizenship:** ☐ 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:**	

HEALTHCARE CENTERS
of MORRIS HOSPITAL

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
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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?

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 _____ **# 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						

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SOCIAL HISTORY

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

HEALTHCARE CENTERS
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GYN HISTORY

Date of Last Menstrual Period: ________________

Age at first period: _____

Age of menopause: ______ ☐ N/A

Last PAP Smear: Date: __________ Were the results normal ☐ Yes ☐ No

Have you ever had an abnormal PAP? ☐ Yes ☐ No
What were the results ______________________________ What actions were taken (if any) ________________________________

Have you had any of the following procedures/condition
☐ Hysterectomy ☐ Colposcopy ☐ Cryo ☐ LEEP ☐ uterine anomoly

History of sexual activity (check all that apply):
☐ None ☐ oral ☐ anal ☐ vaginal ☐ with men ☐ with women ☐ currently active ☐ not currently active ☐ sexual abuse ☐ STDs **Number of sexual partners: _______**

Have you ever had any sexually transmitted diseases
☐ none ☐ genital warts ☐ herpes ☐ chlamydia ☐ gonorrhea ☐ HIV ☐ trichomonas ☐ hepatitis ☐ syphilis ☐ HPV

Current form of contraception
☐ none ☐ withdrawl ☐ condoms ☐ oral contraceptive pills ☐ hormonal IUD ☐ non-hormonal IUD ☐ diaphragm ☐ vaginal ring ☐ tubal ligation ☐ salpingectomy ☐ vasectomy ☐ depo-provera ☐ essure ☐ spermicide ☐ implant ☐ transdermal patch

Other previously used form of contraception (check all that apply)
☐ none ☐ withdrawl ☐ condoms ☐ oral contraceptive pills ☐ hormonal IUD ☐ non-hormonal IUD ☐ diaphragm ☐ vaginal ring ☐ tubal ligation ☐ salpingectomy ☐ vasectomy ☐ depo-provera ☐ essure ☐ spermicide ☐ implant ☐ transdermal patch

OB HISTORY

Total number of Pregnancies (including miscarriages and abortions) _______

Total number of births _______

Number of Full-term Births _______ **Number of Premature Births _______**

Number of Abortions _______ **Number of Miscarriages _______**

Number of Multiple births _______ **Total number of Living Children _______**

Please enter your past pregnancies in the table below:

Delivery Date	Weeks Gestation	Delivery Type		Birth Weight	Infant Gender		Hours in Labor	Type of anesthesia	Location	Provider	Complications
			Vaginal	lbs		Male					
			C-Section	oz		Female					
			Vaginal	lbs		Male					
			C-Section	oz		Female					
			Vaginal	lbs		Male					
			C-Section	oz		Female					
			Vaginal	lbs		Male					
			C-Section	oz		Female					
			Vaginal	lbs		Male					
			C-Section	oz		Female					
			Vaginal	lbs		Male					
			C-Section	oz		Female					