New Patient Registration

Name: ____
First Name Middle Name Last Name

Date of Birth: _______ / _______ / _______ **Gender:** Male Female Non-Binary
Month Day Year Circle One

Marital Status: ____________ **Social Security Number:** _______ - _______ - _______

Home Address: ____

City: ____________________ **State:** ____________ **Zip Code:** ____________

Cell Phone: __________________ **Home Phone:** __________________

***Email Address:** ____
**By providing your email address, you are electing to receive email communication from Raincross Medical Group and its affiliates.*

Primary Language: ____________________

Race: (Circle One) American Indian Asian African American White Other: ____________

Employment Status: (Circle One) Full-Time Part-Time Unemployed Retired

Employer: ____________________ **Occupation:** ____________________

Address: ____

City: ____________________ **State:** ____________ **Zip Code:** ____________

Emergency Contact: ______________________ **Relationship:** ____________

Cell Phone: __________________ **Home Phone:** __________________

I hereby give my permission to contact the above mentioned individual if I cannot be reached. I further give my permission for any treating physician or physician's representative to speak with this person regarding me or my medical condition including but not limited to lab / pathology / diagnostic test result. **Circle One: YES or NO**

Primary Insurance: ____

Group Number: ______________________ **Policy/ID Number:** __________________________

Secondary Insurance: ____

Group Number: ______________________ **Policy/ID Number:** __________________________

Primary Insurance Subscriber: __________________________ **Relationship:** _______________

Date of Birth: _____________________ **Social Security Number:** _________________________

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that ***I am responsible for knowing my benefits / coverage and tests ordered by my physician may NOT be covered****. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% per month finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for the medical serviced and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. Raincross Medical Group cannot render services on the assumption that the charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If Raincross Medical Group has problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I here- by acknowledge that I have read, understand and agree to hereby give consent for treatment.*

Patient Signature: ____ **Date:** ___________________

Health History

Name: ____ **Date:** ____________

Date of Birth: ________________________________

Previous Primary Care Physician: ____

City: ______________________ **Phone Number:** _______________________________

Allergies: Any known drug allergies? *(Circle One)* **YES NO**
Please list all allergies including food, medications and environmental and reaction.

Do you currently take any **medications** on a regular basis? (*Circle One)* **YES NO**
If yes, please list any medications that you currently take on a regular basis (include non-prescriptions).

MEDICATION	DOSE	FREQUENCY

Note: If you are currently taking more medications than the space above allows, please list the additional medications on the back of this form.

Medical History

Illness & Conditions	Surgical History OR Hospitalizations

Gynecological History (women only)

Last Menstrual Period: ________________________

Number of Pregnancies? ______________________

Number of children? ________________________

Have you had an abnormal pap smear? ________

Have you had a hysterectomy? _______________

Have your ovaries been removed? ____________

Sexual History

Do you have sex with MEN WOMEN BOTH

Have you had an HIV test? YES NO

Family History:

Do you have any family history of serious illnesses? If yes, please list them below and indicate which family member.
(ie. Hypertension, diabetes, colon cancer, breast cancer)

Social History:

Marital Status: (Circle One) Single Married Partnered Co-habiting Separated Divorced Widowed

Do you have children/dependents at home? (Circle One) YES NO How many? _______

Are you employed? (Circle One) YES NO Occupation? _____________________________________

What is your highest level of education? (Circle One) High School College Graduate School

Do you of have you ever smoked, vaped or chewed tobacco? (Circle One) YES NO
When? _____________ Quit Date: _______________ #packs/cans __________ for __________ years

Do you drink caffeine? (Circle One) YES NO Type? _______________ How often? _____________

Do you exercise? (Circle One) YES NO Type? ________________ How often? _____________

Do you wear a seat belt? (Circle One) YES NO

Do you have a living will or advance directive? (Circle One) YES NO

If there anything else you would like us to know about your health? __________________________

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