Patient Registration

Patient Information

Last Name:	First Name:	MI:	Date of Birth:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated			Sex: ☐ Male ☐ Female
Address:			Apt #:
City:	State:		Zip:
Home Phone:	Cell Phone:		Work Phone:
Social Security Number:	Email Address:		

We can TEXT patients some information regarding Lab results, Prescriptions, Medications, Referrals, and other general medical information.
Would you like to be notified this way? ☐ Yes ☐ No

Insurance Information

Primary Insurance Name:	Policy/ID No.:	Group No.:
Secondary Insurance Name:	Policy/ID No.:	Group No.:

Emergency Contact Information

Name:	Phone No.:	Relationship:

Pharmacy Information

Name:	Phone No.:		
Address:	City:	State:	Zip:

Mail Order Pharmacy Information

Name:	Phone No.:

Disclosure Information - Who may we share your protected health information with?

Name:	Phone No.:	Relationship:
Name:	Phone No.:	Relationship:
Name:	Phone No.:	Relationship:

_____ Initials	I understand I am required to access the patient portal to see my lab results, or to schedule an appointment to go over the results with a provider.
☐ Yes ☐ No	Would you like to learn more about medspa services from Body by YourClinic? You may be contacted by phone call or text.

PF-200 Acknowledgement of Receipt of Notice of Privacy Practices.

Our practice reserves the right to modify the privacy practices outlined in the notice.
I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed by E.S.Romanelli,MD,PA. I understand I am entitled to receive a copy of your Notice of Privacy Practices.

Name of Patient (Print):	Signature:	Date:
Signature of Patient Representative:	Relationship to Patient:	

Medical History

Last Name: _____ First Name: _____ D.O.B: _____/_____/_____

Check all that apply:

Drug Allergies: _____ **Reaction**: _____
_____ _____
_____ _____

Non-Drug Allergies: Eggs_____ Tape_____ IPV Dye_____ Seafood_____ Other_____
Childhood Illnesses: None significant _____ ADD _____ Asthma _____ Eczema _____
Nasal allergies _____ Other _____

Adult Illnesses	Diagnosis date
Arthritis	_____/_____/_____
Asthma	_____/_____/_____
Bipolar Disorder	_____/_____/_____
Cancer Of: _____	_____/_____/_____
Stroke	_____/_____/_____
Depression	_____/_____/_____
Diabetes	_____/_____/_____
High Cholesterol	_____/_____/_____
GERD/Heartburn	_____/_____/_____
Gestational Diabetes	_____/_____/_____
Glaucoma	_____/_____/_____
Headaches	_____/_____/_____
Heart Attack	_____/_____/_____
CHF/Heart Failure	_____/_____/_____
High Blood Pressure	_____/_____/_____
Thyroid Disease	_____/_____/_____
Pneumonia	_____/_____/_____
Osteoporosis	_____/_____/_____
Other: _____	_____/_____/_____

Hospitalizations (Year : Illness)
_____
_____
_____

Surgeries
_____
_____
_____

Prescribed Medications
_____
_____
_____

Non Prescription Medications
_____
_____
_____

Health Maintenance/Prevention

When was the last time the following tests were performed?

Cholesterol	_____/_____/_____	Flu Vaccine	_____/_____/_____
Prostate/Rectal Exam	_____/_____/_____	Tetanus	_____/_____/_____
PSA	_____/_____/_____	Hepatitis B(3 shots)	_____/_____/_____
Mammogram	_____/_____/_____	TB test/PPD	_____/_____/_____
Dexa Scan/Osteoporosis	_____/_____/_____		
Pap Smear	_____/_____/_____	**What Colon test was done?**	
Pneumonia(Pneumovax)	_____/_____/_____	Flex sigmoidoscopy	When: ____/____/____
Colon Screening	_____/_____/_____	Colonoscopy	When: ____/____/____
		Stool Cards	When:____/____/____

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Social History
Marital Status _____
Occupation _____

Alcohol Consumption
None / Never a heavy drinker _____
Past heavy drinker but quit _____
Drink Socially _____
How many drinks (or beers) per day? _____
How many days per week do you drink? _____

Tobacco Consumption
None / Never _____
I currently smoke _____
How many packs per day? _____
How many packs per week? _____
I live with a smoker _____
I quit smoking _____ # of years ago
If you quit smoking, how many packs per day did you smoke and for how many years?
_____ per day for _____ years.

Substance Abuse / Illegal drug use
None / Never _____

Illegal Drugs used in the past / recovered
Patient admits to:
Marijuana _____
Cocaine _____
Intravenous drug use _____
Narcotics _____
Amphetamines _____
Anabolic Steroids _____
Frequency?
Frequently _____
Infrequently _____
Rarely _____

Exercise
Yes _____ No _____
Frequency?
Frequently _____
Infrequently _____
Rarely _____

Family History

Mother's History
Healthy _____
Deceased due to _____
Significant for:
Diabetes _____
She developed it at the age of_____
High blood pressure _____
Cancer of the _____
She developed it at the age of_____
Stroke _____
Depression _____
Bipolar Disorder _____
Glaucoma _____
Cholesterol abnormality _____
Osteoporosis _____
Thyroid disease _____
Heart disease _____

Father's History
Healthy _____
Deceased due to _____
Significant for:
Diabetes _____
He developed it at the age of_____
High blood pressure _____
Cancer of the _____
He developed it at the age of_____
Stroke _____
Depression _____
Bipolar Disorder _____
Glaucoma _____
Cholesterol abnormality _____
Osteoporosis _____
Thyroid disease _____
Heart disease _____

Other relatives with significant disease

Relationship: _____ Disease: _____
_____ _____
_____ _____
_____ _____