CROSS TRAILS MEDICAL CENTER
YOUR COMMUNITY HEALTH CARE PROVIDER

Welcome!

Name:_____ **DOB:** _____

Health Information: Check any symptom(s) or condition(s) that you currently have or may have had.

- ☐ ADD
- ☐ ADHD
- ☐ AIDS/HIV+
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Anticoagulant Therapy
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ Chemotherapy
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Developmental Disability
- ☐ Diabetes TYPE: 1 2
- ☐ Dialysis Therapy
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Hearing Impaired
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis TYPE: A B C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Paralysis
- ☐ Pregnancy
  DUE DATE:_____
- ☐ Radiation
- ☐ Seizures
- ☐ Shunts
- ☐ Stents
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Vision Impaired

- ☐ NONE

Physician's Name: _____ Physician's Phone #: _____

Last Physical:_____ Height:_____ Weight:_____

Have you had any major surgery? If so, what?_____

_____

Do you have any disease, condition, or handicap not listed above? _____

Medications: Please list ALL ***or*** provide a legible medications list.

- ☐ Aspirin
- ☐ Blood Thinner
- ☐ Osteoporosis
- ☐ Pre-medication
- ☐ No Medications

OTHER: please list here

_____
_____
_____
_____
_____

Allergies: Are you allergic to any of the following?

- ☐ Latex
- ☐ Codeine
- ☐ Penicillin
- ☐ Morphine
- ☐ Sulfa
- ☐ Aspirin
- ☐ NONE

OTHER: (please list)

_____
_____
_____
_____
_____

Smoke Tobacco Use:

- ☐ Currently Use
- ☐ Formerly Use
- ☐ Never Used

Smokeless Tobacco Use:

- ☐ Currently Use
- ☐ Formerly Use
- ☐ Never Used

Dental History:

Last Dental Appointment Date: _____

Former Dentist: _____

What is your reason for rescheduling this appointment? Be specific.

_____

_____

CERTIFICATION: I CERTIFY THAT THE ANSWERS TO THE HEALTH QUESTIONS ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____

Date: _____

CROSS TRAILS MEDICAL CENTER
Patient Registration Form

Revised 4/13/2016

Patient Information

Last Name	First Name	MI	Social Security Number
/ / M / F	Single / Married / Widowed / Divorced		
Birthdate Sex	Marital Status		
Address			
City	State	Zip Code	
Home Phone	Cell Phone	Work Phone	

Ok to leave message? Yes / No

Email Address:_____

Emergency Contact	Relationship to Patient	Home Phone	Work Phone

Responsible Party Information (if other than the patient)

Last Name	First Name	MI	Social Security Number
/ / M / F	Single / Married / Widowed / Divorced		
Birthdate Sex	Marital Status		
Address			
City	State	Zip Code	
Home Phone	Cell Phone	Work Phone	

Do you have a preferred pharmacy? Yes / No

Pharmacy:_____ Phone Number:_____

Address:_____