STARK COUNTY
PHYSICIANS, LLC

REGISTRATION FORM

PERSONAL

Last Name	First	Middle	Today's Date

Is this your legal name? ☐ Yes ☐ No If No, what is your legal name	Former Name	Date of Birth	Age	Sex ☐ M ☐ F

Home Address

Social Security No.	Home Phone No.	Mobile Phone No.
Occupation	**Employer**	**Employer Phone No.**

Chose clinic because/referred to clinic by (Please choose one option) ☐ Referred by: ☐ Reason:

Other family members seen here:

INSURANCE INFORMATION

Please give your insurance card to the receptionist

Person responsible for bill:	Birth date:	Home Phone No:

Is this person a patient here? ☐ Yes ☐ No
Is this patient covered by insurance? ☐ Yes ☐ No
Address (if different)

Occupation	Employer	Employer Address	Employer Phone No

Please indicate **Primary Insurance**:	Other	Patient's relationship to subscriber:

Subscriber's Name	Subscriber's S.S. No	Birth date	Group No:	Policy No:	Co-payment:

Name of **Secondary Insurance** (if applicable) | Patient's relationship to subscriber:

Subscriber's Name	Group Number	Policy Number

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone Work phone

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Stark County Physicians or insurance company to release any information required to process my claims.

Patient /Guardian signature Date

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NEW PATIENT FORM

Full Name

Date of Birth

PAST MEDICAL HISTORY

What medical problems have you been diagnosed with in the past

- Allergic Rhinitis
- Anemia
- Atrial Fibrillation
- Congestive Heart Failure
- Depression
- Enlarged Prostate
- Gastroesophageal Reflux
- Glaucoma
- High Cholesterol
- Obstructive sleep apnea
- Pre-Diabetes
- Urinary Incontinence
- None
- Other
- Alzheimer's Disease
- Aortic Stenosis
- Chronic Obstructive Heart Disease (COPD)
- Coronary Artery Disease
- Diabetes Mellitus Type 2
- Fibromyalgia
- Generalized Anxiety Disorder
- High Blood Pressure
- Hypothyroidism (Low Thyroid)
- Migraine headaches
- Osteoarthritis, Multiple Sites
- Previous Stroke
- PTSD
- Vitamin D deficiency

FAMILY MEDICAL HISTORY

What medical problems run in your family? Please check all that applies

Mother	Father	
		Abdominal Aneurysm
		Asthma
		Cardiovascular (Heart) Disease
		Chronic Obstructive Pulmonary Disease (COPD)
		Congestive Heart Failure
		Diabetes Mellitus, Type 2
		High Blood Pressure
		Hypothyroidism
		Muscular Dystrophy
		Psoriasis
		Seizure or Convulsions
		Systemic Lupus Erythemarosus

Mother	Father	
		Alzheimer's Disease
		Breast Cancer
		Cerebral Aneurysm
		Colon Cancer
		Deep Vein Thrombosis (Blood clot)
		ESRD End Stage Renal Disease
		High Cholesterol
		Lung Cancer
		Polycystic Kidney Disease
		Rheumatoid Arthritis
		Stroke
		None
		Other

ALLERGY

Do you have any Allergies to medications?

- Adhesive Tape
- Quinolones
- Staten-HMG-COA Reductase Inhibitors
- Tetanus
- Penicillin
- Salicylates
- Sulfa (Sulfonamides)
- Tetracyclines
- None
- Other

What are the reactions?

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NEW PATIENT FORM

Full Name ____________ Date of Birth ____________

PAST SURGICAL HISTORY

What surgeries have you had?

- ☐ Appendectomy
- ☐ Carpal Tunnel Release
- ☐ Cervical Spine Surgery
- ☐ C-Section
- ☐ Exploratory Laparotomy
- ☐ Hip replacement: Left Right
- ☐ Lumpectomy: Left Right
- ☐ Pacemaker Implant
- ☐ Rotator Cuff Repair
- ☐ Splenectomy
- ☐ Transurethral Resection of Prostate
- ☐ Vasectomy
- ☐ None
- ☐ Breast Biopsy: Left Right
- ☐ Cataract Surgery
- ☐ Cholecystecomy
- ☐ Dilation & Curettage
- ☐ Hernia Repair
- ☐ Lumbosacral Spine Surgery
- ☐ Mastectomy: Left Right
- ☐ Prostate Biopsy
- ☐ Skin Biopsy
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Wisdom Teeth
- ☐ Other ____________

SOCIAL HISTORY

- ☐ Divorced
- ☐ Married
- ☐ Widowed
- ☐ Other ____________

Do you Drink or use Tobacco products?

- ☐ Alcohol
- ☐ Denies
- ☐ Tobacco

If quit. When did you quit? ____________

If check marked, how much & how many days per week? ____________

PLEASE LIST YOUR MEDICATION

NAME	DOSE	HOW TAKEN