Cecilia Medical Center
Empowering Health, Elevating Lives

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PATIENT REGISTRATION

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: ___/___/_____ SSN: ___-___-____

STREET ADDRESS: _____

CITY/STATE/ZIP CODE: _____

CELL PHONE: (___) _____-_____ HOME PHONE: (___) ____-_____

Gender: Male Female Other

Marital Status: _____ Name of Significant Other: _____

Employment Status: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____

Relationship to Patient: _____

Cell Phone: (___) _____-_____ Home Phone: (___) ____-_____

Would you like this person to be able to pick up medication? Yes No

PHARMACY INFORMATION:

Pharmacy name: _____

Pharmacy Address: _____

Pharmacy Phone: (____) ____-_____ Fax: (____) ____-_____

APPOINTMENT REMINDERS:

- Phone calls (Provide Number): _____

- Text Messages (Provide Number): _____
- Emails (Provide Email): _____

INSURANCE INFORMATION: (Reminder: If you have an HMO Policy that is not open access, please call your insurance company prior to your appointment to discuss billing)

Insurance Provider: _____

Member ID: _____

Group Number: _____

PATIENT HISTORY:

Allergies:

Please list all allergies:

- I currently do not have any known allergies

Medications:

Please list the names and dosage of the medications that you taking (including over the counter)

- I currently am NOT taking any medications

Previous history:

Please, circle if you have been diagnosed with any of the following:

o Adenoid enlargement	o Blood clots/ DVT	o Emphysema
o ADHD	o Breast cancer	o GERD
o AIDS/ Related complex	o Cancer	o High Blood Pressure
o Alcoholism	o Chronic Bronchitis	o HIV

o Anemia	o Chronic tonsilitis	o Hyperthyroidism
o Anxiety	o Benign prostatic hyperplasia	o Hypothyroidism
o Asthma	o Diabetes	o Kidney Disease
o Autoimmune disorder	o Eczema	o Leukemia
o Migraines	Others (Please write below)	List any surgeries you had:
o Nasal Allergies		
o Osteoarthritis		
o Skin cancer		
o Sleep apnea		
o Sleep disorder		
o Stomach ulcers		
o Stroke		
o Throat Cancer		
o TMJ		
o Tuberculosis		

Family history:

Father (please list any medical condition) _____

Mother (please list any medical condition): _____

Siblings (please list any medical conditions): _____

Social History:

- Tabacco use (Circle all that apply): Cigarette Cigars Vaping Smokeless Tabacco
- Alcoholic beverage per week: _____
- Recreational drugs? If so, which one: _____

Home living situation: Circle all that apply:

o Alone	o With spouse	o With children	o With parents
o Nursing home	Assisted living	With friends	Other:

Review of Systems: (Circle all that applies)

Change in sense of smell	Night sweats	Chest pain
Change in thirst	Neck has enlarged	Cold feeling
Chills	Pain in neck	Difficulty swallowing fluids
Diarrhea	Painful eye	Dizziness
Difficulty swallowing	Painful swallowing	Drooping on one side of face
Double vision	Post- nasal drainage	Ear infection
Ear drainage	Restless sleep	Fatigue
Ear pain	Seizures	Congestion
Excessive daytime sleepiness	Sensitivity to light	Nosebleed
Fever	Shortness of breath	Heartburn
Frequent non-productive cough	Sneezing	Hoarse voice
Headache	Spinning Sensation	Hearing loss
Heart murmur	Swelling of ankles	numbness
Hives	Tremor	Tingling
Inhaling food or drink	Unintentional weight gain	Joint pain
Itchy eats	Vomiting	Runny nose
Itchy nose	Change in Appetite	Sleeping problems
Lightheadedness	Bedwetting	Stiff joints
Lumps in armpit	Blacking out or fainting	Trouble swallowing
Lumps in neck	Blurred vision	wheezing
Mouth ulcers	Bruise easily	Lumps in body