Revolution Wellness

Patient Registration

OFFICE USE ONLY

	New Patient
	Current Patient UPDATE

Please Complete All					Date / /	Acct No.	
Patient Name Last	First	Initial			Marital Status: ☐ S ☐ M ☐ D ☐ W		Sex: ☐ M ☐ F
Home Address	City	State	Zip		Home Telephone:		
Employer/School	Employer/School Address				Cellular Telephone:		
Occupation	Social Security Number	Driver's License No. State	Birth Date / /	Age	Living Will? ☐ Yes ☐ No		
Spouse or Parent Name	Employer's Address				Work Telephone		

Insurance Information

Name of Financially Responsible Person (if Different from Patient) ☐ Spouse ☐ Parent ☐ Other				
Address (if Different from Patient)		Home Telephone:	Work Telephone:	
Primary Health Insurance Co. Name	Policy Holder		Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Insurance Co. Address	ID/Policy No.	Group No.	Coverage Code	Effective Date / /
Secondary Health Insurance Co. Name	Policy Holder		Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Insurance Co. Address	ID/Policy No.	Group No.	Coverage Code	Effective Date / /

Contact Information

Emergency Contact:		Relationship to you
Address:		
Telephone Phone:	Cellular Phone:	Work Phone:
Next of Kin:		Relationship to you:
Address:		
Telephone Phone:	Cellular Phone:	Work Phone:

Pharmacy Information

Pharmacy you prefer:	Pharmacy Phone:

Revolution Wellness

Privacy

Your privacy is important to us. Please indicate with whom we may leave messages regarding prescription refills or any other patient information.		
Leave messages on my answering machine or with a person who answers the phone. ☐ Yes ☐ No If No, Please contact me at:		
I understand that my test results are private and will not be released to anyone other than myself unless I authorize it. I request that the following be given test results if I am unavailable.		
Name:	Relationship:	Telephone:
Name:	Relationship:	Telephone:
I understand that the above instructions will be in force until I notify Revolution Wellness of any changes.		
Patient or Legal Guardian Signature:		Date:

Acknowledgement of receipt of Privacy Practice

Acknowledgment of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by request.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient: _____
(Print)

_____
(Signature)

Date: _____

Witness: _____

HEALTH HISTORY INTAKE FORM

Name: **Date:**

Allergies

1 Reactions:

2 Reactions:

Medications

1 6

2 7

3 8

4 9

5 10

Medical History

Allergic rhinitis	Yes/No	Anemia	Yes/No	Arthritis	Yes/No
BPH	Yes/No	Cancer	Yes/No	Renal Insufficiency	Yes/No
Colon polyps	Yes/No	COPD	Yes/No	Coronary artery dise	Yes/No
CVA	Yes/No	Depression	Yes/No	Diabetes mellitus	Yes/No
Erectile dysfunction	Yes/No	GERD	Yes/No	Hyperlipidemia	Yes/No
Hypertension	Yes/No	Hypothyroid	Yes/No	Osteoporosis	Yes/No

Other Medical History

Surgical History

Angioplasty	Yes/No	Appendectomy	Yes/No	Arthroscopy, Knee	Yes/No
C Section	Yes/No	CABG	Yes/No	Cataract Removal	Yes/No
Cholecystectomy	Yes/No	Colectomy	Yes/No	D & C	Yes/No
Hernia Repair	Yes/No	Hysterectomy	Yes/No	Laminectomy	Yes/No
Lumpectomy	Yes/No	Mastectomy	Yes/No	Replacement, Hip	Yes/No
Replacement, Knee	Yes/No	Splenectomy	Yes/No	T & A (Tonsillectomy	Yes/No
Tubal Ligation	Yes/No	Valve Replacement,	Yes/No	Vasectomy	Yes/No

Other Surgical History

Substance History

Tobacco Use: Yes/Never/Quit/Passive Comments:

Packs/Day: 0.25/0.5/1.0/1.5/2.0/3.0 Years:

Quit Date:

Alcohol Use: Yes/No Comments:

Types of Drinks: Glass(es) of wine:

Can(s) of beer:

Shot(s) of liquor:

Drink(s) containing 0.5 oz of alcohol:

Drug Use Yes/No Comments:

Per Week 1/2/3/4/5/10/15 Types:

ADL and other Concerns

Military Service	Yes/No	Comments:
Blood Transfusion	Yes/No	Comments:
Caffeine Concern	Yes/No	Comments:
Occupational Expos	Yes/No	Comments:
Hobby Hazards	Yes/No	Comments:
Sleep Concern	Yes/No	Comments:
Stress Concern	Yes/No	Comments:
Weight Concern	Yes/No	Comments:

Special Diet	Yes/No	Comments:
Back Care	Yes/No	Comments:
Exercise	Yes/No	Comments:
Bike Helmet	Yes/No	Comments:
Seat Belt	Yes/No	Comments:
Self-exams	Yes/No	Comments:

Health Maintenance – Last Done?

Mammogram	
Pap/Pelvic Exam	
Clinical Breast Exam	
PSA	
DRE (Rectal Exam)	
Cholesterol	
Colonoscopy/Sigmoidoscopy	
Stool Occult Cards	
Bone Density	
Calcium Scoring	
Eye Exam	
Stress Test	
Pulmonary Function Testing	
CXR	
DtaP/DT	
Flu Shot	
Pneumovax	
PPD Skin Test	

Family History

Relationship	Status	Medical Conditions
Mother		
Father		
Brothers		
Sisters		
Maternal Aunts		
Maternal Uncles		
Paternal Aunts		
Paternal Uncles		
MGMother		
MGFather		
PGMother		
PGFather		
Other		

Comments

Sexual Activity

Sexually active: Yes/No/Not Currently Sex of partner? Female/Male

Birth control: Condom/Pill/Diaphragm/IUD/Surgical/Spermicide/Implant/Rhythm/Injection/Sponge/Inserts