

PATIENT REGISTRATION FORM

(please print)

PATIENT INFORMATION

Form fields for Patient Information including name, marital status, social security, race, ethnicity, language, and contact information.

RESPONSIBLE PARTY INFORMATION

Form fields for Responsible Party Information including name, social security number, phone numbers, and address.

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Form fields for Primary Insurance Information including insured name, employer, company, and policy details.

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Form fields for Secondary Insurance Information including insured name, employer, company, and policy details.

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. Patient (Or Responsible Party) Signature Date

Occupational and Family Medicine of South Texas
dba Kirkwood Medical Associates

4001 Preston Avenue Ste #110 Pasadena, TX 77505

281-249-2273 phone 281-249-2282 fax

Patient Name: _____ DOB: ____/____/____

MEDICAL PROBLEMS

Have you had any of the following? (Circle any that apply)

High blood pressure	heart disease	heart attack	stroke
Diabetes	arthritis	HIV/Aids	breast cancer
Colon cancer	anemia	hepatitis/jaundice	asthma
Liver/pancreas problems	thyroid disease	tuberculosis	sickle cell
Urinary infections	emphysema	kidney stones	seizures
Abnormal PAP	blood transfusions	STD's	other

If other, describe them _____

PAST SURGERIES

Have you had any of the following (Circle any that apply)

Appendix	spine/joint	hysterectomy	thyroid	lung	D&C
Hernia	gallbladder	tubal ligation	tonsillectomy	heart	C-Section
Orthopedic	cataract L/R	breast biopsy L/R	kidney L/R	colon	ovaries

If other, describe them _____

Marital Status: _____

WOMAN ONLY

Do you suspect that you are pregnant? Yes No

If yes, Due Date: _____

Are you Nursing? Yes No

Taking Birth Control Pills/Shot? Yes No

Last Menstrual Period: _____

SOCIAL HISTORY

Do you currently or have you ever used tobacco products? Yes No

What type? _____ Amount used daily? _____

Do you consume alcohol? Yes No

Amount consumed daily? _____

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FAMILY HISTORY

	Age	Disease	Deceased/Cause of Death
Mother:	_____	_____	_____
Father:	_____	_____	_____
Sibling 1:	_____	_____	_____
Sibling 2:	_____	_____	_____

MEDICATIONS

Are you taking any medication Prescribed, Non-Prescribed or Natural? Yes No

If yes, list them. Please indicate dosage and directions.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES

Are you allergic to any medications? Yes No

If yes, please give name of medication and kind of reaction.

_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY

Name of Pharmacy _____

Address _____

Phone Number _____ Fax Number _____

Patient Signature

Date

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Patient Name: _____ Date: _____

Thank you for choosing our office for your medical care. Our providers and staff are dedicated to provide excellent quality healthcare to each of our patients. Kirkwood Medical Associates, Company Care and Bayside Urgent Care would like to invite you to participate in our Patient Satisfaction Survey. Our survey will be sent to you via email, after your visit. This survey will help us to ensure that you have a pleasant experience and let us know how to improve to serve you better. Your time spent filling out the survey is greatly appreciated.

Email Address: _____

Please let us know how you heard about our clinic (circle one)

- Work
- Google
- Insurance
- Newspaper
- Health Fair
- Yellow Pages
- Word of Mouth
- Hospital Referral
- Physician Referral
- Chamber of Commerce
- Resource Guide
- Drive by
- Other: _____