Hope Medical Clinic P.A

3609 Cape Center Drive, NC 28304

Phone: 910.500.0909 Fax : 910.920.4224

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patients' Full Name:- _____
Date Of Birth:- _____ Age: _____ Social Security No:- _____
Address:- _____ Apt. # _____
City:- _____ State:- _____ Zip Code:- _____
Home Phone No:- _____ Mobile/Cell:-_____
Sex:- Male _____ Female_____ Race/Ethnicity:-_____
Marital Status:- □ Single □ Married □ Divorced □ Widowed
Name of Partner/Spouse: _____ Number of Children: _____
Drivers' License No:-_____ Email:-_____

EMERGENCY CONTACT

Emergency contact:- _____ Relationship to Patient:-_____
Address:- _____ Phone No:-_____

EMPLOYMENT INFORMATION

Patients' Employer:- _____ Occupation: _____
Employment Status:- □ Full Time □ Part Time □ Unemployed □ Retired □ Student □ Other

INSURANCE INFORMATION

1. Primary Insurance Company:- _____
Subscriber/Policy Holder:-_____Relationship to Patient:-_____
Address:- _____
SS#:- _____ DOB _____/_____/_____ Cell Phone:-_____
Employer Name:-_____
Employer Telephone (_____)_____ Occupation_____

2. Secondary Insurance Company:- _____
Subscriber/Policy Holder:-_____Relationship to Patient:-_____
Address:- _____
SS#:- _____ DOB _____/_____/_____ Cell Phone:-_____
Employer Name:-_____
Employer Telephone (_____)_____ Occupation_____

PERSON RESPONSIBLE FOR BILLS (IF OTHER THAN THE PATIENT)

Name:- _____ Relationship to Patient:-_____
Address:- _____ Phone No:-_____
Social Security No: _____ D.O.B: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the abovenamed patient.
Name(s):- _____ Relationship to Patient:-_____

HEALTH INFORMATION

I. Names/ Specialties/ Location of Other Physicians Caring for you, including previous primary Physician.
1. Name of Physician: _____ Specialty: _____
Location of Physician: _____
Reason for Visit: _____
2. Name of Physician: _____ Specialty: _____
Location of Physician: _____
Reason for Visit: _____
3. Name of Physician: _____ Specialty: _____
Location of Physician: _____
Reason for Visit: _____
Date of Last completed Physical Exam: _____ Date of Last Blood Work: _____
Date of Last Colonoscopy: _____ Date of Last Tetanus Shot: _____
Last Hospitalization:- _____Hospital: _____
Reason for Hospitalization_____

II. Information about Tobacco use, Drug use, Alcohol use, Exercise & Diet:
Do you smoke? □ Yes □ No Do you vape? □ Yes □ No
Do you drink Alcohol? □ Yes □ No Do you exercise? □ Yes □ No
Any history of illegal drug use? □ Yes □ No If Yes, what type? _____
Are you on a special diet? If so, what? _____

FOR FEMALE PATIENTS ONLY

Date of Last Menstrual Period: _____ Date of Last Pap Smear: _____
History of Abnormal Pap? □ Yes □ No If yes, list date/s: _____
Date of Last Mammogram: _____ DEXA: _____
Number of Pregnancies: _____ Miscarriage: _____ Termination: _____
Living Children: _____ Method of Contraception: _____

IF YOU or YOUR FAMILY MEMBER have had any of the following, please circle and indicate which family member when applicable:

ADD/ADHD ☐	Type 1 or 2 Diabetes ☐	Respiratory Disease ☐
Anemia ☐	Fractures ☐	Skin Disease ☐
Allergis/Hay Fever ☐	High Blood Pressure ☐	Stomach/Colon Disease ☐
Asthma ☐	High Cholesterol ☐	Stroke ☐
Arthritis ☐	Heart Attack ☐	Seizure Disorder ☐
Anxiety/ Depression ☐	Kidney Disease ☐	Thyroid Disorder ☐
Alcoholism ☐	Liver Disease ☐	Gynecological Disease ☐
Blood Clots ☐	Neurological Disease ☐	Sexually Transmitted Disease ☐
Cancer, Type: _____	Osteopenia/Osteoporosis: _____	Other: _____

Please list any SURGERIES you have had and please state the month and year:

_____

_____

_____

Who referred you to our office? _____

Does the Patient have other family members who are also our patients? _____

_____

I hereby give authorization to release information to pay benefits to Hope Medical Clinic P.A. I hereby assign payment directly to the designated provider for any medical/surgical procedures performed. I agree to be responsible for payment of service determined by my insurance carrier as not medically necessary or noncovered service. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

**Photo ID is required for identification purpose only. **

Signature of Patient:_____ Date:_____

LIST OF MEDICATION/S CURRENTLY TAKEN BY PATIENT

Patients' Name: _____ D.O.B: _____

Your Pharmacy: _____

Pharmacy Address: _____

Pharmacy phone No: _____

Please List any medication you are currently taking, whether it is prescribed or over the counter. If you need more space, please ask for more pages or use the back of this page :-

1. Medication: _____
   Dosage: _____
   Directions: _____
2. Medication: _____
   Dosage: _____
   Directions: _____
3. Medication: _____
   Dosage: _____
   Directions: _____
4. Medication: _____
   Dosage: _____
   Directions: _____
5. Medication: _____
   Dosage: _____
   Directions: _____
6. Medication: _____
   Dosage: _____
   Directions: _____
7. Medication: _____
   Dosage: _____
   Directions: _____

Any allergy to medication or Food (list reactions): _____

_____

_____