HVCH Rural Health Clinic
Adult Registration Form

Date _____

Please Print Clearly Social Security # _____-_____-_____

Name (as listed with insurance): _____

Preferred Name: _____DOB: _____ Sex: Male Female

Mailing Address: _____

Physical Address: _____

City: _____State: _____ Zip:_____

Home Phone: _____Work: _____ Cell: _____

Email: _____

Pharmacy Name & Location_____

Student Status: FT Student PT Student
Employment Status: Full-Time Part-Time Unemployed Retired Disabled

Employer: _____Occupation: _____

Martial Status: Single Married Divorced Widowed Separated

Race:_____ Ethnicity: **Hispanic/Latino** or **Not Hispanic/Latino** Language:_____

Who may we discuss this patient's medical information with (I.e appointments, test results, prescriptions etc.)

Name: _____Relationship: _____Phone:_____

Name: _____Relationship: _____Phone:_____

Emergency Contact: _____ Relationship: _____Phone: _____

Insurance Information

PRIMARY Insurance: _____ID#_____

Subscriber's Name: _____Relationship: _____

Subscriber's DOB: _____ Subscriber's Social Security Number: _____

SECONDARY Insurance: _____ID#_____

Subscriber's Name: _____ Relationship: _____

Subscriber's DOB: _____ Subscriber's Social Security Number:_____

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Medication List

Patient Name:_____

Date of Birth: _____

List all medications, including prescription medication from all physicians, over-the-counter medications, herbal supplements, and vitamins. If you don't know please call your pharmacist to confirm. This list will need to be approved and every patient will have an OARRS report completed.

Medication name	Dose (mg)	Instructions	Prescribing Doctor

Allergies

Please list all allergies to medications, foods, and/or the environment (bees, pollen, mold, etc) and reaction such as rash, hives, anaphylaxis, etc.

Allergen/Medication	Reaction	Severity of Reaction

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Name:_____ DOB:_____
Date of Last Physical Exam_____ Previous Doctor:_____

HEALTH HISTORY & PHYSICAL

SOCIAL HISTORY: (Please circle/fill in all that apply)

Recreational Drug Use: Currently / Past / Never

Smoking: Currently / Past / Never Packs/day:_____

Alcohol: Currently / Past / Never Drinks/day:_____

Caffeine: Currently / Past / Never Drinks/day:_____

PERSONAL MEDICAL HISTORY: (Please circle/fill in all that apply)

ADHD	COPD	Hiatal Hernia	Osteoporosis
Alcoholism	Dementia	High Blood Pressure	Vascular Disease
Allergies, Seasonal	Depression	High Cholesterol	Psoriasis
Anemia	Diabetes: 1 or 2	HIV	Pulmonary Embolism
Anxiety	Diverticulitis	Hepatitis	Rheumatoid Arthritis
Arrhythmia (Irregular Heart Beat)	DVT (Blot Clot)	Irritable Bowel Syndrome	Sciatica
Arthritis	Eczema	Kidney Stones	Seizure Disorder
Bipolar	Emphysema	Kidney Disease	Sleep Apnea
Bladder problems/Incontinence	Gallstones	Lupus	Stroke
Bleeding problems	GERD (Acid Reflux)	Liver Disease	Thyroid Disorders
Cancer: _____	Glaucoma	Macular Degeneration	Ulcers
Carpal Tunnel	Headaches	Migraines	Ulcerative Colitis
Chemical Dependency	Heart Disease	Nosebleeds	
Crohn's Disease	Heart Attack (MI)	Neuropathy	

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HEALTH MAINTENANCE:

Menstrual Period / Menopause	Date:	Normal / Abnormal
Colonoscopy	Date:	Normal / Abnormal
Mammogram	Date:	Normal / Abnormal
Dexa (Bone Density)	Date:	Normal / Abnormal
Eye Exam	Date:	Normal / Abnormal
Flu Vaccine	Date:	
Pneumonia Vaccine	Date:	

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE:

_____

_____

SURGICAL HISTORY: (Please list all prior surgeries and approximate dates performed)

_____ _____

_____ _____

_____ _____

FAMILY HISTORY:

FATHER: Living: Age_____ Deceased: Age_____

Alcoholism	Bipolar	COPD	Heart Disease	Kidney Disease
Anemia	Blood Clot	Dementia	High Blood Pressure	Osteoporosis
Arthritis	Cancer: _____	Depression	High Cholesterol	Stroke
Asthma	Chemical Dependency	Diabetes 1 or 2	Kidney Disease	Thyroid Problems

Other: _____

MOTHER: Living: Age_____ Deceased: Age_____

Alcoholism	Bipolar	COPD	Heart Disease	Kidney Disease
Anemia	Blood Clot	Dementia	High Blood Pressure	Osteoporosis
Arthritis	Cancer: _____	Depression	High Cholesterol	Stroke
Asthma	Chemical Dependency	Diabetes 1 or 2	Kidney Disease	Thyroid Problems

Other:_____

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FAMILY HISTORY (continued):

SIBLINGS:

Alcoholism	Bipolar	COPD	Heart Disease	Kidney Disease
Anemia	Blood Clot	Dementia	High Blood Pressure	Osteoporosis
Arthritis	Cancer: _____	Depression	High Cholesterol	Stroke
Asthma	Chemical Dependency	Diabetes 1 or 2	Kidney Disease	Thyroid Problems

Other: _____

List other Medical Providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney specialist, Substance Abuse clinics, etc.)

_____
_____
_____
_____

Patient Signature: _____ Date_____

FOR OFFICE USE ONLY!!!!

- ☐ Registration
- ☐ Insurance
- ☐ Medical Records Release
- ☐ HIPAA
- ☐ H&P
- ☐ Medication List
- ☐ Preloaded by: _____

Provider Reviewed: _____ Date: _____

***DO NOT SCHEDULE UNTIL ALL ITEMS ARE COMPLETED AND REVIEWED/ACCEPTED BY PROVIDER**