REGISTRATION FORM

Referred by:			PCP name:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Date of birth:	
Marital Status:	Preferred language:	Sex:	Education:	Email:

Address:		
Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Is it ok to leave a detailed voicemail:
Yes No If Yes: Preferred contact no:

INSURANCE INFORMATION

(**Please give your insurance card to the receptionist**.)

Person responsible for bill:	Birth date:	Address (if different from above):	Phone no:
Social security #:	Relationship to patient:		
Occupation:	Employer:	Employer address:	Employer phone no.:

Primary Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber:

Secondary insurance:	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize East Bay Rheumatology Medical Group, Inc. to release any information required to process my claims.

Patient/Guardian signature ______________________ Date ______________

Name: ______________________________
DOB: ______________________________

List of Doctors:
1.)____
2.)____
3.)____
4.)____
5.)____

A.) What is your reason for coming to East Bay Rheumatology Medical Group?

B.) Past Medical History:
Please list all medical conditions, serious illnesses or injuries, surgeries and hospitalizations.

Condition, Surgery, Hospitalization	Date

C.) Family History:

Relationship	Age	Medical Problems

D.) Medication list:

Medication Name	Dose	Frequency	Reason for taking

E.) Allergy or Drug reaction list:

Kind of Allergy/ Drug Allergy	Type of Reaction

F.) Tobacco/ Alcohol use:
Tobacco per day:______________ How many years have you smoked?______________
If you have stopped smoking, when did you quit? ________________________

Alcohol per day: ________________ ( )Daily ( ) Occasionally

Name: ______________________________
DOB: ______________________________

G.) Review of Systems (ROS): Are you troubled with or do you have a history of:

Musculoskeletal:	( ) Swollen joints	( ) Red joints	( ) Joint pains
	( ) Back pain	( ) Muscle weakness	( ) Warm joints
	( )Jaw pain from chewing	( ) Discoloration of fingers upon cold exposure	
	( ) Stiffness (more than 10 minutes) in the morning or after rest		
Urinary:	( ) Kidney stones	( ) Urethral Discharge	( ) Blood in urine
	( ) Cloudy or smoky urine	( ) Burning with urination	( ) STD
	( ) Difficulty starting or stopping flow of urine		( ) UTI
	( ) Frequency or urgency of urination		
Skin:	( ) Rash (where?)	( ) Psoriasis	( ) Hives
	( ) Lump or nodules	( ) Skin tightness	( ) Loss of hair
	( ) Sensitivity to sunlight	( ) Skin ulcers	
Metabolic:	( ) Thyroid problems	( ) Cold intolerance	( ) Hot flashes
	( ) Excessive urination	( ) Heat intolerance	( ) Excessive thirst
	( ) Skin dryness	( ) Excessive appetite	
Blood:	( ) Low white cells	( ) Low platelets	( ) Anemia
	( ) Frequency or unusual infection		( ) Easy bruising
	( ) Serious blood clot requiring blood thinner		
	( ) Difficulty with blood clotting		
General:	( ) Swollen glands/lymph nodes	( ) Loss of appetite	( ) Fever
	( ) Tender glands/Lymph nodes	( ) Weight loss	( ) Weight gain
	( ) Weakness	( ) Nervousness	( ) Night sweats
	( ) Excessive fatigue	( ) Bleeding (not menstrual)	
Neurologic:	( ) Depression or mood changes	( ) Memory loss	( ) Seizures
	( ) Tingling in one or more extremities		( ) Stroke
	( ) Headache	( ) Dizziness	( ) Convulsions
	( ) Weakness or numbness in one or more extremities		( ) Loss of consciousness
Eyes:	( ) Poor or changing vision	( ) Eye Inflammation	( ) Double vision
	( ) Eye dryness or grittiness	( ) Pain or redness	( ) Uveitis
Ears:	( ) Deafness	( ) Ringing in ears	
Nose:	( ) Sinus Trouble	( ) Post nasal drips	( ) Nosebleeds
	( ) Ulcers or sores in nose		
Mouth:	( ) Ulcers or sores in mouth	( ) Dryness of mouth	( ) Loss of taste
	( ) Dental problems		
Throat:	( ) Hoarseness	( ) Sore throats	
Heart & Lungs:	( ) Shortness of breath	( ) Chest pain	( ) Cough
	( ) Leg or feet swelling	( ) Wheezing	( ) Fast heartbeats
	( ) Sputum production	( ) Coughing up blood	( ) Irreg. heartbeats
GI:	( ) Difficulty swallowing	( ) Abdominal pain	( ) Nausea
	( ) Diarrhea	( ) Heartburn	( ) Vomiting
	( ) Constipation	( ) Jaundice	( ) Hepatitis
	( ) Vomiting of blood or coffee-ground material		

Name: ______________________________
DOB: ______________________________

H.) Because of health problems, do you have difficulty (please check appropriate response):

	YES	NO
Using your hands to grasp small objects?(buttons, pencils, tootbrush,etc)		
Walking?		
Climbing stairs?		
Descending stairs?		
Sitting down?		
Getting up from chair?		
Touching your feet while seated?		
Reaching behind your head?		
Reaching behind your back?		
Dressing yourself?		
Going to sleep?		
Staying asleep due to pain?		
Obtaining restful sleep?		
Bathing?		
Eating?		
Working?		
Getting along with other family members?		
In your sexual relationship?		
Engaging in leisure time activities		
With morning stiffness?		
Do you use a cane, crutches, a walker or a wheelchair?		