Chesapeake
SURGICAL ASSOCIATES

Patient Registration Form

1.

Date Completed ________________

Employee Initial ________________

Patient Information

Name (First, MI, Last) | Sex | Home Phone

Address (Street) | Social Security Number

City, State, Zip | DOB | Marital Status

Employer | Job Title | Work Phone | Cell Phone

Name and phone number of emergency contact | Relationship to patient

Pharmacy | Location | Phone

Referring Physician Information

Referred By | Office Phone

Address

Primary Care of Family Physician | Office Phone

Address

Would you like us to send a copy of your visit to your referring/family doctor? (circle) Yes No

Financial Responsibility - If Minor

Name of person financially responsible (if patient is a minor) | Relation to Patient

Address (Street, City, State, Zip) **If different than patient**

Phone | DOB | Social Security Number

Insurance Information

Primary Insurance Carrier | ID Number

Policy Holders Name (First, MI, Last) | Specialist's Co-Pay Amount

Address (Street, City, State, Zip) **If different than patient**

Phone | Relationship | DOB | Sex

Employer | Social Security Number | Effective Date of Insurance

Secondary Insurance Carrier

Policy Holder's Name | Relationship to Patient

Patient Signature | Date

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Medical History

Allergies to medication and your reaction: ____________________

Current medication and doses: ____________________

____

____

Do you have, or have you ever had the following problems: *Circle Yes or No*

Stroke	Yes	No	Kidney Stones	Yes	No	Diabetes	Yes	No
Seizures	Yes	No	High Blood Presure	Yes	No	Cancer (Type:__________)	Yes	No
Thyroid Disease	Yes	No	Reflux disease	Yes	No	HIV/AIDS	Yes	No
Heart Attack When: __________	Yes	No	Irritable Bowel	Yes	No	Blood Transfusion When: __________	Yes	No
			Diverticulosis	Yes	No			
Asthma	Yes	No	Irreg Heart Beat	Yes	No	Reaction To Anesthesia Reaction: __________	Yes	No
Emphysema (COPD)	Yes	No	Stomach Ulcers	Yes	No			
Sleep Apnea	Yes	No	Hepatitis B C	Yes	No	Radiation Exposure	Yes	No
Fibromyalgia	Yes	No	Arthritis	Yes	No	Bleeding Problems	Yes	No

Other: ____________________

Surgical History

Please list past surgical procedures:

____

____

Social History

Do you drink alcohol? Yes No Quit (When?__________)

If yes how much? ____________________

Do you smoke? Yes No Quit (When?__________)

If yes how much? ____________________

Are you pregnant? Yes No

If yes, date of expectancy: ____________________

Family History (Other than yourself)

Do any of your immediate family members (blood relatives) suffer from: *Circle Yes or No*

Diabetes	Yes	No	Cancer, Breast	Yes	No	Irritable Bowel	Yes	No
Seizures	Yes	No	Cancer, Ovarian	Yes	No	Gallstones	Yes	No
Hypertension	Yes	No	Cancer, Colon	Yes	No	Stomach Ulcers	Yes	No
Heart Disease	Yes	No	Cancer, Other	Yes	No	Other	Yes	No

____________________ Patient Signature

__________ Date

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Review of Systems

Do you ***currently*** have any of the following:

	Circle Yes or No	
Good General Health	Yes	No
Constitutional		
Recent Weight Loss	Yes	No
Recent Weight Gain	Yes	No
Night sweats, fevers	Yes	No
Fatigue	Yes	No
Cardiovascular		
Chest pain	Yes	No
Palpitations	Yes	No
Heart Trouble	Yes	No
Swelling hands/feet	Yes	No
Musculoskeletal		
Muscle pain or cramps	Yes	No
Stiffness/swelling joints	Yes	No
Joint pain	Yes	No
Trouble walking	Yes	No
Genitourinary		
Blood in urine	Yes	No
Pain with urination	Yes	No
Urinating difficulty	Yes	No
Eyes		
Glasses/Contacts	Yes	No
Blurred/double vision	Yes	No
All others negative (For office use)	**Yes**	**No**

	Circle Yes or No	
Ears/Nose/Mouth/Throat		
Hearing loss or ringing	Yes	No
Sinus problems	Yes	No
Nose bleeds	Yes	No
Sore throat	Yes	No
Voice change	Yes	No
Respiratory		
Shortness of breath	Yes	No
Cough	Yes	No
Wheezing	Yes	No
Coughing up blood	Yes	No
Hematologic/Lymphatic		
Bruise easily	Yes	No
Slow to heal	Yes	No
Enlarged glands/nodes	Yes	No
Gastrointestinal		
Nausea	Yes	No
Vomiting	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Blood in stool	Yes	No
Integumentary		
Keloids (Abnormal Scarring)	Yes	No
Rash	Yes	No
Puritis/itching	Yes	No

Patient Signature ______________________ Date ____________

Thank you. Please return this to the front desk and we will be with you as soon as possible.

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Gina Massoglia, M.D.