

DESERT OASIS HEALTHCARE PATIENT REGISTRATION FORM

(Please Print)

Today's date:	PCP:
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PATIENT INFORMATION

Patient Name (Last, First, Middle)

Email	Birth date:	Age:	Sex:
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Home Phone:	Cell Phone: (We use this number for SMS texting)
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Physical Address:

City:	State:	ZIP Code:
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Mailing Address (if different):

How do you wish to be contacted? (Select One)	Home Number	Cell Number	Patient Portal
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Occupation:	Preferred Language:
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Preferred Pharmacy:	City and Cross Street of Pharmacy:
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Race: (Indicate/Select all that apply) African American Black White American Indian Alaska Native Asian Native Hawaiian or other Pacific Islander	Ethnicity (Select One): Hispanic or Latino Not Hispanic or Latino
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Emergency Contact Name:	Relationship:
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Emergency Contact Date of Birth:	Emergency Contact Phone:
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BILLING INFORMATION

Please give your insurance card to the receptionist

Person responsible for bill:	Home Phone:
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Birth date:	Address (if different from above):
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Relationship to patient:	Cell Phone: (We use this number for SMS texting)
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Occupation:	
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Retired? Yes No

Primary Insurance:

Medicare ID Number:

Subscriber's Name:	Birthdate:
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Patient's relationship to subscriber: Self Spouse Child Other

Secondary Insurance:	ID #:
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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 Desert Oasis healthcare or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	Date:
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DESERT OASIS HEALTHCARE PATIENT HEALTH QUESTIONNAIRE

(Please Print)

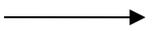
Today's Date:	PCP:
Patient Name: (Last, First, Middle)	
Birth Date:	
Drug and Food Allergies :	Reaction:
Pharmacy Name:	
Do you have an Advanced Healthcare Directive? <input type="checkbox"/> Medical Power of Attorney <input type="checkbox"/> POLST <input type="checkbox"/> None <input type="checkbox"/> Don't Know	

I HAVE BEEN TREATED FOR THE FOLLOWING: (check all that apply)

- | | | | | |
|--|--------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bypass | <input type="checkbox"/> Blackout | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> STD Type: |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Seizures | <input type="checkbox"/> Numbness | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine | <input type="checkbox"/> Tremor | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Breast Mass | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Cancer | Type: _____ | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Broken Bone | <input type="checkbox"/> Bipolar |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Overactive Bladder | <input type="checkbox"/> HIV | <input type="checkbox"/> |

<u>Medication you take</u> (List milligrams and how many you take per day)	<u>Why are you taking it?</u>
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.

<u>Family History</u> (Which family member had the following:) Guide: M=Mother F= Father B=Brother S=Sister MGM=Mat.Grandmother MGF=Mat.Grandfather PGM=Pat.Grandmother PGF=Pat. Grandfather	<u>Surgical History</u> (List operation and year performed:)
Diabetes	
Cancer	
Heart Disease	
Hypertension	
Stroke	
Anemia	
Other	



Hand Dominance: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ambidextrous	Education Level Completed:
Military Experience <input type="checkbox"/> Yes <input type="checkbox"/> No	Biohazard Exposure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possible
What Branch :	
Do you have children <input type="checkbox"/> Yes <input type="checkbox"/> No How Many: _____Boys _____Girls	Do you drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly _____drinks per day _____per week
Do you smoke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly <input type="checkbox"/> Cannabis _____Packs per day _____Year Quit _____Number of years smoked	
Consume caffeine: <input type="checkbox"/> Yes <input type="checkbox"/> No _____Cups per day Type Consumed: <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda	
Housing Status: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless	
Who comprises your social network: <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other	
Activity Level: <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	
What type of exercise do you do:	
Hobbies/Activities:	
Diet History: <input type="checkbox"/> Normal <input type="checkbox"/> Special Diet-Please specify:	
Animals in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type (circle all that apply) Birds Dogs Cats Rodents Reptiles Other _____	
Do you clean up after animals? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have guns in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, are they locked? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is religion/spirituality an important part of your life? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you agree to receive blood/blood products if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you regularly travel out of the country? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Thank you for your completion of this important information.

Patient/Responsible Party Signature_____

Date_____