DESERT OASIS HEALTHCARE
PATIENT REGISTRATION FORM

(Please Print)

Today's date:	**PCP:**

PATIENT INFORMATION

Patient Name (Last, First, Middle)

Email	**Birth date:**	**Age:**	**Sex:**

Home Phone:	**Cell Phone:** (We use this number for SMS texting)

Physical Address:

City:	**State:**	**ZIP Code:**

Mailing Address (if different):

How do you wish to be contacted? (Select One) ☐ **Home Number** ☐ **Cell Number** ☐ **Patient Portal**

Occupation:	**Preferred Language:**
Preferred Pharmacy:	**City and Cross Street of Pharmacy:**
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 ☐
Emergency Contact Name:	**Relationship:**
Emergency Contact Date of Birth:	**Emergency Contact Phone:**

BILLING INFORMATION

Please give your insurance card to the receptionist

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

Primary Insurance:

Medicare ID Number:

Subscriber's Name:	**Birthdate:**

Patient's relationship to subscriber:	☐ **Self**	☐ **Spouse**	☐ **Child**	☐ **Other**

Secondary Insurance:	**ID #:**

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:**

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? ☐ Medical Power of Attorney ☐ POLST ☐ None ☐ Don't Know

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

☐ Diabetes	☐ Bypass	☐ Blackout	☐ Thyroid Disorder	☐ STD Type:
☐ Hypertension	☐ Blood Clots	☐ Seizures	☐ Numbness	☐ Heart Attack
☐ Stroke	☐ Glaucoma	☐ Migraine	☐ Tremor	☐ Depression
☐ Amputation	☐ Breast Mass	☐ High Cholesterol	☐ Arthritis	☐ Anxiety
☐ Cancer	Type:_____	☐ Heartburn	☐ Broken Bone	☐ Bipolar
☐ Anemia	☐ COPD	☐ Ulcer	☐ Hepatitis	☐ Other
☐ Heart Disease	☐ Seizures	☐ Overactive Bladder	☐ HIV	☐

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

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

→

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

Thank you for your completion of this important information.

Patient/Responsible Party Signature_____

Date_____