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Encompass Pediatrics LLC

Delivering exceptional Healthcare
Phone: 401-728-9208

New Patient Registration Form

Patient's Name (Last, First, MI): ____

Patient's Home Phone Number: ____________________ Alternate Phone Number (☐ cell or ☐ work): ____________________

E-Mail Address: ____

Address: ____ Apt. # __________

City: ________________________ State: ______________ Zip: ______________

Date of Birth: ________________ Age: _____ Sex: M F Social Security Number: ______________________

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient's Employer: ______________________

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed [ ] Retired [] Student [ ] Other: ____________

Emergency Contact: ________________________________ Relationship to Patient: ______________________

Address: ____ Phone number: ____________________

INSURANCE INFORMATION - We will request to scan your ID and insurance card

Primary Insurance: ________________

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: ________________

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION(if other than the patient)

Subscriber/ Policy Holder: ________________________________ Relationship to Patient: ____________________

Address: ____

Social Security Number: __________________________

Date of Birth: ________________________________

His or Her Employer: ____________________________ Work Phone Number: __________________________

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient. Please ask for additional sheet if required.
Name(s): ____________________________________ Relationship to Patient: __________________________

Cancellation Fee schedule: Encompass Family Medicine reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice
2. Are missed without calling to cancel (no show)

Cancellation Fee: $20
Patient / Parent or Guardian Signature: ____ Date: ________________

HEALTH HISTORY

Personal Information Date:_______________

Patient Name: ___________________________________ Birth Date: _____/_____/_____ Age: ____

Occupation ___________________ Marital Status: ______ Name of Partner/Spouse: ________________

Race: [ ] Asian [ ] Black or African American [ ] Native American [ ] White / Caucasian

[ ] Other: ____________

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: _______________________

Number of children: ______ Children's Names/Ages: ____

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor:____

____

____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): ____

Preferred **Pharmacy**: ____

Date of Last Complete Physical Exam: _____________ Date of Last Blood Work: ____________________

Date of Last Colonoscopy: _______________ Date of Last Tetanus Shot: __________________________

For Females: Date of Last Menstrual Period: _________ Date of Last Pap Smear: __________________

History of Abnormal Pap (list date/s)? ___________ Date of Last: Mammogram: _____ DEXA: ______

Number of Pregnancies: ________ Miscarriages: ______ Terminations: _______ Living Children: _____

Method/s of Contraception: ____

If **YOU** or a **FAMILY MEMBER** has had any of the following, please circle and indicate which family member when applicable:

ADD/ADHD		Type 1 or 2 Diabetes		Respiratory Disease	
Anemia		Fractures		Skin Disease	
Allergies/Hay Fever		Gynecological Disease		Stomach/Colon Disease	
Asthma		High Blood Pressure		Stroke	
Arthritis		High Cholesterol		Seizure Disorder	
Anxiety/Depression		Heart Attack		Thyroid Disorder	
Alcoholism		Kidney Disease		Sexually Transmitted Disease	
Blood Clots		Liver Disease		Other:	
Cancer, Type/s		Neurological Disease		________________________	
__________________________		Osteopenia/Osteoporosis			
		____________________________			

Please list any **SURGERIES** you have had and include the month/year:

____

____

____

____

Social Information

Tobacco Use: Do you smoke? _____ If so, how many cigarettes/cigars per day: _____ No. of years smoking: _____ Do you chew tobacco? _____ Have you thought about quitting? _____ Have you quit before? ____ How long?____

Alcohol Use: Do you drink alcohol? ____ If so, what type? ____________ How many in 1 week? _____

Drug Use: Any history of illegal drug use? _____ If so, what type/s? __________ When? ____________

Do you **exercise**? _____ What activities do you do, and how often in 1 week?______________________

____

Are you on any special **diet**? _____ If so, what? ____

Do you consume any **caffeinated** products? _____ If so, what and how much per day? ______________

Have you recently noticed an increase in sadness or gloominess? _____

Have you lost interest in enjoyable activities? _____