VIOLA STARTZMAN
CLINIC

NEW PATIENT REGISTRATION FORM

Today's Date______________________

Patient Name (First, Middle, Last) ____________________________________**Date of Birth** _____/_____/_____

Social Security Number: _____ - _____ -_____ **Preferred Language:**_____________________________

Marital Status: Single Married Divorced Legally Separated Widowed

Race: White/Caucasian Black/African American Asian/Pacific Islander Native American/Indian Multi-racial Other_____________ Prefer not to answer

Ethnicity: Non-Hispanic / Latino Hispanic / Latino Prefer not to answer

Sex at Birth: Male Female **Pronoun:** He She They We Other_________

Gender Identity: Male Female Non-binary Other___________ Prefer not to answer

Sexual Orientation (check all that apply): Heterosexual / Straight Gay / Lesbian / Queer Bisexual Asexual Questioning Other__________________ Prefer not to answer

Pharmacy ____

How did you hear about our clinic? ____

CONTACT INFORMATION:

Home Address:__________________________ City ______________State ___________Zip________________

Mailing Address:_________________________ City _______________ State___________ Zip________________

Phone: ________ - ________ - ________ May we leave a message here? Yes No May we text? Yes No

Alternate Phone: _____-_____-_______ May we leave a message here? Yes No May we text? Yes No

Email address: ____

Emergency Contact______________________________ **Phone**_____________________________

Employer____ Employer Phone_____________________

Employment Status: Full Time / Part Time / Retired / Unemployed / Self Employed / Active Military

INSURANCE INFORMATION

**Policy holder is the person who is the main insurance holder. If this is employer-sponsored insurance, it will be under the name of the person who is employed.*

Name of Insurance__________________________ Name of Policy Holder: ___________________________

Policy Holder Date of Birth _____/_____/______ Policy Holder SSN ______-_______-_________

Insurance ID #_____________________________ Group #_______________________________________

**You will need to provide a copy of your photo ID and insurance card at check in.*

Please check if you do not have insurance and/or are worried about cost for any medical treatment. We have programs that may help you access affordable care.

RESPONSIBLE PERSON

Complete for minors of when patient is not financially responsible for this account.

Name of Responsible Person: ___________________________________Relation____________________

Phone___________________________ Date of Birth ____/____/_____ SSN _____/_____/______

Mailing Address__________________________ City_______________ State__________ Zip____________

PATIENT HEALTH QUESTIONNAIRE

Patient Name (First, Middle, Last) ____**Date of Birth** ____/____/____

Primary Complaint: ____

____

ALLERGIES
(Please consider allergies to food, medications, environmental factors, etc.)

No known allergies
Yes, I have the following allergies:

____
____

CURRENT MEDICATIONS

List both prescription and over the counter medications and supplements you take.

Name:	Dosage:	Frequency:
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

MEDICAL CONDITIONS Please check the conditions you currently have or have had in the past:

ADD/ADHD
Allergies
Anemia
Anxiety
Arthritis
Asthma
Bipolar Disorder
Bleeding disorder
Cancer, type
Cholesterol
COPD
Congestive Heart Failure/Heart disease
Depression
Diabetes
Emphysema
GERD
Glaucoma
Headaches/Migraines
Heart Attack
Hepatitis ____
Herpes
High Blood Pressure
HIV/AIDS
Insomnia
Kidney Disease
Meningitis
Neuropathy
Osteoporosis
Prostate Problem
Seizures/Epilepsy
Stroke
Substance abuse
Thyroid Problem
Other
____
____
____

SURGICAL HISTORY Please check the surgeries you have had in the past and include the date:

Appendectomy ____________________________
Brain Surgery ____________________________
Breast Surgery ____________________________
Colon Surgery ____________________________
Cosmetic Surgery ____________________________
C-Section ____________________________
Eye Surgery ____________________________
Fracture Surgery ____________________________
Gallbladder Surgery ____________________________
Hernia Repair ____________________________
Hysterectomy ____________________________
Prostate Surgery ____________________________
Joint Replacement ____________________________
Spine Surgery ____________________________
Tonsillectomy ____________________________
Vasectomy ____________________________
Tubal Ligation ____________________________
Valve Replacement ____________________________
Other ____________________________
____

FAMILY HISTORY

Mom: Alive or Deceased — Medical History: ______________________
Dad: Alive or Deceased — Medical History: ______________________
Paternal Grandmother: Alive or Deceased — Medical History: ______________________
Paternal Grandfather: Alive or Deceased — Medical History: ______________________
Maternal Grandmother: Alive or Deceased — Medical History: ______________________
Maternal Grandfather: Alive or Deceased — Medical History: ______________________
Other: ______________ — Medical History: ______________________
Other: ______________ — Medical History: ______________________

SOCIAL HISTORY (Please circle or fill in)

Alcohol Use: Yes or No — Drinks per day/week: ________

Tobacco: Yes or No PPD: ____ — Smokeless Tobacco: Yes or No — Vape: Yes or No

Illegal Drug Use: Yes or No — Type: ______________

Sexually Active: Yes or No — Partners: Female or Male — Contraception: ____________

If you are female, please answer the following questions: Current Age__________

	Yes	No	Date and Location of most recent test
Have you ever had a colonoscopy?	Yes	No	
Have you ever had a mammogram?	Yes	No	
Have you ever had a pap smear / cervical cancer screening?	Yes	No	
Do you smoke / vape?	Yes	No	Date of last lung CT
Have you been to the dentist in the last year?	Yes	No	Date of last visit

Last Menstrual Period: _________
Full Term Pregnancies: _________ Miscarriages/Abortions: __________ Total Living: _________

If you are male, please answer the following questions: Current Age_____________

	Yes	No	Date and Location of most recent test
Have you ever had a colonoscopy?	Yes	No	
Do you have a history of prostate cancer in your family?	Yes	No	N/A
Have you ever had a PSA test?	Yes	No	
Do you smoke / vape?	Yes	No	Date of last lung CT
Have you been to the dentist in the last year?	Yes	No	Date of last visit

If you have diabetes please answer the following questions:

	Yes	No	Date and Location of most recent test
Have you ever had a diabetic foot exam?	Yes	No	
Have you ever had a diabetic eye exam?	Yes	No	N/A

IMMUNIZATIONS Date of last vaccine:

Tetanus: ________________ Influenza: ______________

Pneumococcal: _______________ Shingles: ______________

ADDITIONAL COVID-19 INFORMATION

Have you at any point tested positive for COVID-19? No Yes, Date of Diagnosis_____________

Have you been fully vaccinated against COVID-19? No Yes

Have you had a COVID Booster? No One Two