



The Health & Wellness Center

Dr. Cecil A. Schodroski FND-C, DNP

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name <small>(as it appears on insurance card or ID)</small>		
Sex	Marital Status	Date of Birth (Age)		Social Security Number	
Patient's Address			City	State	Zip
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone		Pharmacy Address		

Patient Employer/School Information

Employer/School		Occupation	Employer/School Phone		
Employer/School Address			City	State	Zip

Emergency Contact Information

Emergency Contact Name		Emergency Contact Phone	Relation to Patient
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Billing and Insurance

Primary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School			
Insured's Name <small>(as it appears on insurance card or ID)</small>			Relation to Patient		Insured's Phone Number
Insured's Address			City	State	Zip
Insured's Social Security Number	Insured's Birthdate				

Secondary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School		Insured's Social Security Number	
Insured's Name <small>(as it appears on insurance card or ID)</small>			Relation to Patient		Insured's Phone Number

Responsible Party

Billing Name <small>(if other than patient)</small>		Phone	Relation to Patient		
Address			City	State	Zip

Reason for Visit

What brings you to the office today?

How is your general health?

Excellent Good Fair Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Allergies

Are you allergic to any of the following?

Adhesive Tape Antibiotics Latex
 Barbiturates (Sleeping Pills) Aspirin Iodine
 Codeine Sulfas Local Anesthetics

Do you have any other allergies?

Name	Reaction
<hr/>	<hr/>
<hr/>	<hr/>

Past Medical History

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Ear Problems	<input type="checkbox"/> Hepatitis - A, B, or C	<input type="checkbox"/> Measles	<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Joint Disorder	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stroke	

Hospitalizations & Surgeries

<hr/>	<hr/>
<hr/>	<hr/>

Women Only:

<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

Family History

Has anyone in your family ever had any of the following conditions?

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Joint Disorder
<input type="checkbox"/> Allergies	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disorder
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Migraines
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Psychiatric Disorders
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disorder

Details:

Lifestyle Factors

Are you sexually active?

Yes No # of partners in past year _____

Do you wish to be checked for STDs?

Yes No

Has anyone in your home ever physically or verbally hurt you?

Yes No

Have you ever smoked?

Yes No # of years _____ # packs/day _____

Do you smoke now?

Yes No # packs/day _____

Do you use recreational drugs?

Yes No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____



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Medical Information Release Form
(HIPAA Release Form)

Name: _____ DOB: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- Spouse _____
- Child(ren) _____
- Other _____

Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell Number: _____

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- other: _____

The best time to reach me is (day) _____ between(time) _____

Signature: _____ Date: _____