Family Medicine
Dr. Ghassan A. Atto M.D.
Dr. Maath Alani M.D.

New Patient Registration

Staff Use Only: PID#:________________ Scanned by (Initials): __________

Patient Arrival Time: ________________ AM / PM

Demographics

Patient Information: *Need help with Forms?* ☐ *Y* ☐ *N* | Preferred Language: ☐ English ☐ Spanish ☐ Other: __________

Name: (LAST) ______________________ (FIRST)______________________ (MI)______ (Suffix) ______

Minor ☐ Y ☐ N Date of Birth: _____/_____/_____ Social Security (Optional):_____-_____-_____ Sex: ☐ M ☐ F

Street Address: ______________________________________ (Apt #) _____ (City) __________

(State)__________ (Zip) ______ (Country) ______ Home Phone: __________ Cell Phone: __________

Best Form of Contact: ☐ Home Phone ☐ Cell Phone | Best Time: _____ | May *we leave a detailed voice message?* ☐ Y ☐ N

Email: ______________________________ Please do ***not*** contact me for: ☐ PHI ☐ Marketing

Primary Care Physician: (Name)______________ (Phone)______________ (City) __________

Preferred Pharmacy: (Name) ______________ (Location) ______________ (Phone) __________

Emergency Contact: (Name) ______________ (Phone) ______________ (Relationship)__________

Guarantor: Is your address the same as the Patient/Minor's address? ☐ Yes ☐ No | ***If no***, provide information below.

Name of Guarantor: ______________________ Guarantor Date of Birth: _____/_____/_____

Street Address: ______________________________________ (Apt #) _____ (City) __________

(State)__________ (Zip) ______ (Country) ______ Home Phone: __________ Cell Phone: __________

How Did You Hear About Immediate Clinic? ______________________________

Patient Authorization to Release Medical Records (To a Doctor or Family Member)

☐ **Patient Authorization to Release Medical Records:** I authorize the custodian of records or other person/entity (specifically describe) to disclose/release the following information* (check all applicable): ☐ All Records ☐ Billing Records ☐ Other __________

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or STDs, you are hereby authorizing disclosure of this information. **To (Name):** ______________________ **Relationship:** __________

Signature of Patient (or Guardian):______________________________ Date: _____/_____/_____

☐ **Insured** –Primary Ins Subscriber Name: ______________ Secondary Ins Subscriber Name:______________

Name of Primary Ins: ______________ Name of Secondary Ins: ______________

Primary Subscriber Number: ______________ Date of Birth: *(if not patient)* __________ Relationship: __________

Secondary Subscriber Number: ______________ Date of Birth: *(if not patient)* __________ Relationship: __________

☐ **Auto** – Name of Ins: ______________ Phone: __________ Accident/Claim #:__________

☐ **Work Related** - Company Name: ______________ DER (Company Representative): __________

Company Phone Number: ______________ Email: ______________

☐ **Self-Pay** (FFS)

Patient's Additional History

ALLERGIES ❍ None ❍ I am allergic to latex ❍ I am allergic to band-aids

❍ Yes, medication allergies: ______________________________

❍ Yes, other allergies: ______________________________

CURRENT MEDICATIONS (include birth control, vitamins, supplements, herbals, over the counter & prescriptions)

Medication Name & Dose	Medication Name & Dose	Preferred Pharmacy
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	
____________	____________	

Past Medical History (ex. cancer, diabetes, high blood pressure, depression, surgery)

Medical Conditions: ______________________________ ❍ None

Surgeries: ______________________________ ❍ None

Major Accidents: ______________________________ ❍ None

Other: ______________________________

FAMILY HISTORY Please list any diseases that your immediate family have. List relative and disease.

Relative: ____________ Disease(s): ____________

Relative: ____________ Disease(s): ____________

Relative: ____________ Disease(s): ____________

❍ None ❍ Adopted

Is there a chance you are pregnant? ❍ Yes ❍ No **Do you have a pacemaker?** ❍ Yes ❍ No

SOCIAL HISTORY

TOBACCO USE ❍ Never Smoked ❍ Smoker in home ❍ Smokeless Tobacco/e-cigarettes

❍ Current Smoker ___ packs/day for ___ years ❍ Former Smoker ___ packs/day for ___ years

DRUG USE ❍ Never Used

❍ Current User ❍ Methamphetamines ❍ Marijuana ❍ Cocaine ❍ Heroin ❍ Steroids ❍ PCP ❍ Acid ❍ Inhalants
amount ________ for ________ years

❍ Former User ❍ Methamphetamines ❍ Marijuana ❍ Cocaine ❍ Heroin ❍ Steroids ❍ PCP ❍ Acid ❍ Inhalants
amount ________ for ________ years

ALCOHOL USE ❍ Never Used

❍ Current Drinker ____ drinks/day/week/month for ___ years ❍ Former Drinker ____ drinks/day/week/month for ___ years

EXERCISE ❍ Do not exercise

❍ Exercise regularly _____ minutes/day for ____ days/wk

CAFFEINE ❍ Do not drink caffeinated beverages

❍ Current caffeine ______ drinks/day for _____ years

Clinic Staff Use Only: ______________________________

____

____

Patient Name: ____________________ Patient Date of Birth: ____________________