



NEW PATIENT REGISTRATION FORMS  
Please fill out the form completely.

**1. Patient Information**

Full Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_

Gender  Male  Female  Other  Prefer not to say

Marital Status  Single  Married  Divorced  Widowed

Social Security Number (SSN) \_\_\_\_\_

Preferred Language \_\_\_\_\_

Employer \_\_\_\_\_

Interpreter Needed?  Yes  No

**Based on Government regulations, we are required to ask for the following information:**

Race:  American Indian/Alaska Native  Asian  
 Black  Native Hawaiian or Other Pacific Islander  
 White  Other

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Preferred Language \_\_\_\_\_

**2. Medical Information**

Primary Care Provider (if any) \_\_\_\_\_

Reason for Today's Visit \_\_\_\_\_

Do you have any allergies?  Yes  No

If yes, please list: \_\_\_\_\_

Current Medications \_\_\_\_\_

Past Surgeries/Hospitalizations \_\_\_\_\_

Chronic Conditions (e.g., diabetes, hypertension) \_\_\_\_\_

**3. Insurance Information**

Do you have insurance?  Yes  No

Insurance Company Name \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number (if applicable) \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**4. Contact Information**

Home Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Primary Phone \_\_\_\_\_

Alternate Phone \_\_\_\_\_

Call or Text?  Call  Text

Email Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Emergency Contact Phone \_\_\_\_\_



## 5. Consent/Authorization & Acknowledgement

By providing this authorization I release my Personal Health Information (PHI) to the following individual(s), I understand that the authorization is voluntary and is being done at my request. I understand that I also may refuse to sign this authorization, and my treatment and/or payment obligation will not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy rules. I understand that I may revoke this authorization at any time by notifying Martin Medical Center in writing, but if I do, it will not have any effect on the uses or disclosures prior to the receipt of revocation. I understand that this authorization is for 1 year until specified otherwise. I hereby authorize Martin Medical Center to use and disclose health information to the following:

Patient Signature:

X: \_\_\_\_\_ Date: \_\_\_\_\_

### GAURANTOR INFORMATION

Name: _____	Street Address: _____
Gender: _____	_____
Date of Birth: _____	City/State/Zip: _____
SSN: _____	_____

Check if Same as patient info

I acknowledge full financial responsibility for any services rendered and I understand that payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefit to this office.

Patient Signature:

X: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT TO TREAT:** I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment. I also understand that Martin Medical Center is required to obtain records of my medical history.

I acknowledge that I have been given and have read the Notice of Privacy Practices for Martin Medical Center.

Patient Signature:

X: \_\_\_\_\_ Date: \_\_\_\_\_

MARTIN MEDICAL CENTER, P.C.  
Patient Health Questionnaire (PHQ-9)

Name : \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

Over the last two weeks, how often have you been bothered by any of the following Problems?  
(Circle the number of your answer.)

QUESTIONS:	Not At All	Several Days	More Than Half the Days	Nearly Everyday
1.) Little interest or pleasure in doing things.	0	1	2	3
2.) Feeling down, depressed or hopeless.	0	1	2	3
3.) Trouble falling or staying asleep or sleeping too much	0	1	2	3
4.) Feeling tired or having little energy.	0	1	2	3
5.) Poor Appetite or Overeating.	0	1	2	3
6.) Feeling bad about yourself or that you are a failure or have let yourself/family down.	0	1	2	3
7.) Trouble concentrating on things, such as reading or watching T.V.	0	1	2	3
8.) Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9.) Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3
Add Columns				
Total:				

10.) If you checked off any problems, how difficult have these problems made it of you to do your work, take care of things at home, or get along with other people?

Not difficult at all \_\_\_\_\_ Very difficult \_\_\_\_\_

Somewhat difficult \_\_\_\_\_ Extremely difficult \_\_\_\_\_

MARTIN MEDICAL CENTER, P.C.  
 Personal/Family Medical History

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**TOBACCO USAGE**

Do you smoke/use tobacco products ?  Yes  No  Vape  Dip/Snuff/Smokeless

How many cigarettes do you smoke a day?  1 - 2  2 - 3  3 - 4  4 - 5  Other

How many cans of smokeless/chewing tobacco do you use a day?  ½  1  1 ½  2  2 ½ +  Other

How many cigar/pipes do you smoke a day?  ½  1  1 ½  2  2 ½ +  Other

What age did you begin smoking? \_\_\_\_\_

If you quit smoking, what age did you quit? \_\_\_\_\_

What describes your smoking habit?  Every Day  Some Days  
 Previous  Never  Other

**ALCOHOL USE**

Do you drink alcoholic beverages ?  Yes  No  Occasionally

How many drinks do you have a day?  1 - 2  2 - 3  3 - 4  4 - 5  Other

How many times per week?  1 - 2  2 - 3  3 - 4  4 - 5  Other

What kind of Alcohol do you drink? \_\_\_\_\_

What age did you start drinking? What age did you quit? \_\_\_\_\_

What describes your drinking habit?  Every Day  Some Days  
 Previous  Never  Other

**Caffeine**

Types of Caffeine:	Tea	Coffee	Soft drinks/Energy drinks
Drinks Per Day:	Occasionally 3-5	0 6-9	1-2 10+

**Exercise**

Types of Exercise:	Bicycling Walking	Running Aerobics	Swimming Other:
Times Per Week:	Occasionally 3-4	0 5-6	1-2 7+

MARTIN MEDICAL CENTER, P.C.  
Personal/Family Medical History

Patient Name & DOB: \_\_\_\_\_

**YOUR Medical History**

- |   |  |
|---|--|
| <input type="radio"/> Alcohol Abuse               | <input type="radio"/> High Blood Pressure                                    |
| <input type="radio"/> Anemia                      | <input type="radio"/> High Cholesterol                                       |
| <input type="radio"/> Anesthetic Complication     | <input type="radio"/> HIV  |
| <input type="radio"/> Anxiety Disorder            | <input type="radio"/> Hives  |
| <input type="radio"/> Arthritis                   | <input type="radio"/> Kidney Disease   |
| <input type="radio"/> Autoimmune Problems         | <input type="radio"/> Liver Disease  |
| <input type="radio"/> Asthma                      | <input type="radio"/> Liver Cancer   |
| <input type="radio"/> Birth Defects               | <input type="radio"/> Lung/Respiratory Disease                               |
| <input type="radio"/> Bladder Problems            | <input type="radio"/> Lung Cancer  |
| <input type="radio"/> Bleeding Disease            | <input type="radio"/> Mental Illness   |
| <input type="radio"/> Blood Clots                 | <input type="radio"/> Migraines  |
| <input type="radio"/> Blood Transfusions          | <input type="radio"/> Osteoporosis   |
| <input type="radio"/> Bowel Disease               | <input type="radio"/> Prostate Cancer  |
| <input type="radio"/> Breast Cancer               | <input type="radio"/> Rectal Cancer  |
| <input type="radio"/> Cervical Cancer             | <input type="radio"/> Reflux/GERD  |
| <input type="radio"/> Colon Cancer                | <input type="radio"/> Seizures/Convulsions                                   |
| <input type="radio"/> Depression                  | <input type="radio"/> Severe Allergy   |
| <input type="radio"/> Diabetes                    | <input type="radio"/> Sexually Transmitted Disease                           |
| <input type="radio"/> Growth/Development Disorder | <input type="radio"/> Skin Cancer  |
| <input type="radio"/> Heart Attack                | <input type="radio"/> Stroke/CVA of Brain                                    |
| <input type="radio"/> Heart Pain/Angina           | <input type="radio"/> Suicide Attempt  |
| <input type="radio"/> Heart Disease               | <input type="radio"/> Thyroid Problems                                       |
| <input type="radio"/> Hepatitis A                 | <input type="radio"/> Ulcer  |
| <input type="radio"/> Hepatitis B                 | <input type="radio"/> Other Disease, Cancer, or Significant Medical Illness. |
| <input type="radio"/> Hepatitis C                 | <input type="radio"/> NONE of the Above                                      |

Is there anything we should know about your medical history?

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MARTIN MEDICAL CENTER, P.C.  
Personal/Family Medical History

Patient Name & DOB: \_\_\_\_\_

***FAMILY Medical History***

Please Indicate if YOUR FAMILY has had a history of the following: (**ONLY** include parents, grandparents, siblings, and children.)

- |  |   |
|--|---|
| <input type="radio"/> Alcohol Abuse    | <input type="radio"/> High Blood Pressure           |
| <input type="radio"/> Anemia           | <input type="radio"/> High Cholesterol              |
| <input type="radio"/> Anesthetic       | <input type="radio"/> Kidney Disease                |
| <input type="radio"/> Arthritis        | <input type="radio"/> Lung/Respiratory Disease      |
| <input type="radio"/> Asthmas          | <input type="radio"/> Migraines                     |
| <input type="radio"/> Bladder Problems | <input type="radio"/> Osteoporosis                  |
| <input type="radio"/> Bleeding Disease | <input type="radio"/> Rectal Cancer                 |
| <input type="radio"/> Breast Cancer    | <input type="radio"/> Seizures/Convulsions          |
| <input type="radio"/> Colon Cancer     | <input type="radio"/> Severe Allergy                |
| <input type="radio"/> Depression       | <input type="radio"/> Stroke/CVA of Brain           |
| <input type="radio"/> Diabetes         | <input type="radio"/> Thyroid Problems              |
| <input type="radio"/> Heart Disease    | <input type="radio"/> Other Cancer                  |
|  | <input type="radio"/> <b>Family History Unknown</b> |

Please list what side of the family the medical history is from:

Maternal:

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Paternal:

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MARTIN MEDICAL CENTER, P.C.  
Surgery Medical History

Patient Name & DOB: \_\_\_\_\_

Please Mark a Choice:

- I have had no Surgeries
- I have had Surgeries.

Have you had any Major/Minor Surgeries?

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Do you have any Upcoming Surgeries?

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Have you ever had Radiation or Chemotherapy?

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Have you ever had a Blood Transfusion?

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PATIENT NAME \_\_\_\_\_

MEDICAL RECORD # \_\_\_\_\_

## Medicare Secondary Payer Form

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation? **Yes No**
2. Is illness covered by the Black Lung Program, Veterans Administration or research program? **Yes No**
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? **Yes No**
4. Is patient covered by a large group health plan through either the patient's employer or spouse's current employer and the plan is primary over Medicare? **Yes No**
5. Medicare Beneficiary's (Patient) Retirement Date \_\_\_\_\_
6. Is the patient entitled to Medicare based on Disability? **Yes No**

### Registrar Notes:

A. If patient responds "no" to questions 1-4, Medicare is primary.

B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

Name of Insurance Company \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_  
\_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Policy Number \_\_\_\_\_

Policy Holder's Employee Name \_\_\_\_\_

Policy Holder's Employer Address \_\_\_\_\_

Date of Accident (if applicable) \_\_\_\_\_

Patient's / Legal Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_