MMC
Martin Medical Center

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 ar 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:
Gender:
Date of Birth:
SSN:

Street Address: _____
_____
City/State/Zip: _____
_____

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 offic 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	0	1-2
		3-5	6-9	10+
Exercise		Bicycling	Running	Swimming
	Types of Exercise:	Walking	Aerobics	Other:
	Times Per Week:	Occasionally	0	1-2
		3-4	5-6	7+

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

Patient Name & DOB:_____

YOUR Medical History

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

Is there anything we should know about your medical history?

_____

_____

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.)

- ○ Alcohol Abuse
- ○ Anemia
- ○ Anesthetic
- ○ Arthritis
- ○ Asthmas
- ○ Bladder Problems
- ○ Bleeding Disease
- ○ Breast Cancer
- ○ Colon Cancer
- ○ Depression
- ○ Diabetes
- ○ Heart Disease
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Kidney Disease
- ○ Lung/Respiratory Disease
- ○ Migraines
- ○ Osteoporosis
- ○ Rectal Cancer
- ○ Seizures/Convulsions
- ○ Severe Allergy
- ○ Stroke/CVA of Brain
- ○ Thyroid Problems
- ○ Other Cancer
- ○ **Family History Unknown**

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

Maternal:

_____
_____
_____
_____
_____

Paternal:

_____
_____
_____
_____

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?

_____
_____
_____
_____
_____

Do you have any Upcoming Surgeries?

_____
_____
_____
_____
_____

Have you ever had Radiation or Chemotherapy?

_____
_____
_____
_____
_____

Have you ever had a Blood Transfusion?

_____
_____
_____
_____
_____