NEW PATIENT REGISTRATION INFORMATION

Name: ____

Name:____ ___Male ___Female

Address:____Apt #___________

City: ___________________________State: ______Zip Code:____________

Home Phone: ________________Cell Phone: ________________Work Phone: ______________________

Email Address:____

Date of Birth: ________________Age:___________ Social Security Number: _________________________

Employer: __________________________________Occupation:_____________________________

Retired: Yes____ No______

IF THIS PROBLEM IS A PERSONAL INJURY OR WORK RELATED NOTIFY RECEPTIONIST PRIOR TO COMPLETION

EMERGENCY CONTACT INFORMATION:

Name:____________________________________ Relationship:____________________________

Address:__________________________ City:________________ State:______ Zip Code: ______________

Phone #:_________________________

INSURANCE INFORMATION

Medicare Patients: Medicare # __________________Is Medicare your primary insurance? Yes___ No____

Insurance Co: _______________________________Phone #:_________________________

Address: _____________________________City: _______________State: ____Zip Code:______________

Policy/ID#: _____________________Group #: ____________________________

Policy Owners Name: __________________________ Policy Owners DOB: __________

Policy Owners SS#:________________________

SECONDARY INSURANCE INFORMATION Relation to insured: Self Spouse Child Other

Insurance Co: _______________________________Phone #:_________________________

Address: _____________________________City: _______________State: ____Zip Code:______________

Policy/ID#: _____________________Group #: ____________________________

Policy Owners Name: __________________________ Policy Owners DOB: __________

Policy Owners SS#:________________________

Group # or Employee: ______________________

Check One: HMO______ PPO______ Did you bring a Referral Slip? Yes ____No____

HOW DID YOU HEAR ABOUT DR. HAYTER?

Seminar___ Live Locally____ Referred by a patient_________________________________

Physician ___ Other __________________________________

Name and Address of Primary Care Physician: ____

____Phone Number: ___________________________

Do you have a Cardiologist: Yes____ No___ Name:____

Phone Number:_________________________

Pharmacy Name and Phone Number: ____

MEDICAL HISTORY

Name: ____

CARDIAC

CHECK ALL THAT APPLY **____NONE**

___High Blood Pressure
___Low Blood Pressure
___Heart Attack or Coronary Age ____
___Chest pain or Angina
___Cardiac arrhythmia/irregular heart beat
Type________________
___Heart Failure/Cardiomyopathy
___Heart Murmur
___Valvular Heart Disease Which Valve____________
___Difficulty sleeping due to Coughing or Shortness of Breath
___Blood clot in Leg ___Blood Clot in Lung
___Shortness of breath while walking up steps

Have you had:

___Stress Test Date___________
___Echocardiogram Date___________
___Catheterization Date___________
___Coronary Stent Date___________
___Angioplasty Date___________
___Open Heart Surgery Date___________

RESPIRATORY

CHECK ALL THAT APPLY **___NONE**

___Shortness of breath
___Asthma ___Wheezing ___COPD ___Emphysema
___Sleep Apnea
___Use Oxygen ___CPAP ___BPAP
___Have you every had an abnormal Chest X-ray
___Do you have a cold/flu at this time

MUSCLE OR JOINT

CHECK ALL THAT APPLY **____NONE**

___Muscle Weakness
___Back Problems
___Neck Problems
___Sciatica Treatment ______________
___Neck or Jaw Problems

NEUROLOGICAL PROBLEMS **____NONE**

CHECK ALL THAT APPLY

___Stroke
___Epilepsy or Seizures ___# per month
___Headaches ___Migraines ___# per month
___Paralysis ___Weakness/numbness in arms or legs
___Dizziness ___Fainting
___Treatment by a psychiatrist

URINARY OR REPRODUCTIVE

CHECK ALL THAT APPLY **____NONE**

___Burning or pain during urination ___Frequent Urination
___Kidney or bladder infections ___Kidney Stones
___Kidney Disease Describe ______________________________
___Are you on dialysis
___Prostate problems
___Blood in urine
___Could you be pregnant
Start date of last menstrual Period_______

GASTROINTESTINAL PROBLEMS

CHECK ALL THAT APPLY **____NONE**

___Vomiting blood ___Black or bloody stools
___Stomach pains ___Treated for ulcers
___Jaundice or Hepatitis ___Cirrhosis or enlarged liver

METABOLIC OR BLOOD DISORDERS

CHECK ALL THAT APPLY **____NONE**

___Diabetes ____Insulin How Much ________________
___Anemia
___Bleed easily ___Difficulty clotting
___Nose bleeds
___Sickle Cell Disease
___Blood Transfusions Date of last transfusion_________
___Cortisone or Steroid Use Dose_________________

EAR, NOSE, EYE AND/OR THROAT

CHECK ALL THAT APPLY **____NONE**

___Glaucoma or other eye problem Type____________________
___Serious mouth, throat or larynx problem Type______________
___Nose or jaw surgery Type______________________________
___Dentures ___Bridges/Crowns ___Loose/chipped teeth
___Braces ___Contact lenses
___Hard of hearing

OTHER

CHECK ALL THAT APPLY **____NONE**

___Unplanned weight loss in the past 4 months
___Loss of appetite
___Cancer or tumors Describe___________________________
___Depression
___History of reaction to jewelry or other metals
___Are you under treatment of any specialist
Describe ____
___Anxious or anxiety about potential surgery

MEDICAL HISTORY

Name____

Height _________________ **Weight _________________**

Describe any illness that have required hospitalization and include date:

____

____

____

Describe any illness that required frequent visits to your doctor:

____

____

List any past surgeries and the date:

____

____

____

Difficulty with Anesthesia/Sedation: CHECK ALL THAT APPLY

___Nausea and/or Vomiting ____Waking up _____Putting in a breathing tube Other: ______________________________________

Family member/relative that has had difficulty with anesthesia including High Fever Describe:

____

Are you allergic to local anesthesia ____xylocaine ____Novocain

Have you had prolonged bleeding after tooth extraction or any type of bleeding problems ___YES ___NO

Do you have problems with your neck or jaw ___YES ___NO

CURRENT MEDICATIONS **NONE ______**

LIST ALL CURRENT MEDICATION INCLUDING VITAMINS/HERBS/OVER THE COUNTER MEDS

NAME	**DOSAGE**	**FREQUENCY**
________________________________	______________________	_________________________________
________________________________	______________________	_________________________________
________________________________	______________________	_________________________________
________________________________	______________________	_________________________________
________________________________	______________________	_________________________________
________________________________	______________________	_________________________________
________________________________	______________________	_________________________________
________________________________	______________________	_________________________________
________________________________	______________________	_________________________________
________________________________	______________________	_________________________________

ARE YOU ALLERGIC TO: ___Penicillin ___Sulfa ___Codeine ___Iodine ___Novocain ___Latex or Rubber

Describe Reaction: ____

Other medication allergies: ____

FAMILY AND SOCIAL HISTORY

Name: ____

____Married ___Single ___Widowed ___Divorced

____Live alone ___Children If yes, how many______

Mother ___Living ___Deceased Cause of Death:______________________ Age_______

Father ___Living ___Deceased Cause of Death:______________________ Age_______

Has any of your Blood Relatives had:

___Heart Attack or Coronary Age____

___Rheumatoid Arthritis Age____ ____Osteoarthritis Age ____

Do you have a Living Will ___YES ___NO

How often do you exercise: ___Daily ___2-3 x a week Other _________________

What type of exercise do you do:

____

Do you have any Dietary Restrictions: ___YES ___NO Type: _________________________

Do you use Recreational Drugs: ___YES ___NO

What type: __________________Last Used: _____________

Are you currently a smoker ___YES ___NO ____Packs per day for _____years

Did you quit smoking ___YES When: ____+1 year ___+5 years ___+10 years

Prior to quitting how much did you smoke ______packs per day for _____years

Do you drink alcohol: __YES Type: _________________________ ____NO

How much: ____Daily ___1-2x a week ___1-2x a month ___Rarely

________________________________ ______

PATIENT DATE

Date of Date Entry_______

Initials __________

________________________________ ______

RONALD HAYTER, M.D. DATE