SFHC
Whole family, whole health

STEINMANN FAMILY HEALTH CLINIC

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Language Preference: English Spanish Other: _____	Race: Asian Black White Other: _____	Ethnicity: Hispanic Non-Hispanic

Patient's Legal Name:	Age:	Sex	Birth Date:

Preferred name and pronouns:	Former names:	Cell Phone: ( )

Street Address:	Social Security#.:	Home Phone: ( )

Apt/Unit #:	City:	State:	ZIP Code:

Email Address:	Employer:	Employer Phone: ( )

If patient is a minor,
name of parents/legal guardians:

Preferred Pharmacy:

INSURANCE INFORMATION

Person responsible for bill:	Birth Date: / /	Address (if different than patient):	Home Phone: ( )

Occupation:	Employer:	Employer Address:	Employer Phone: ( )

Please indicate primary
insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth Date: / /	Policy no.:	Group no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name & Birth Date:	Policy no.:	Group no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Steinmann Family Health Clinic or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Patient History

Name:_____ Date of Birth:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Medical History: Please check any that apply.

☐ Diabetes	☐ Migraines	☐ Seizures	☐ STD's
☐ Cancer	☐ Mental Illness	☐ Back Pain	☐ Scoliosis
☐ Hepatitis	☐ Asthma	☐ Heart Disease	☐ Stroke
☐ Thyroid	☐ Heartburn	☐ TB	☐ Obesity
☐ Joint Pain	☐ Lung problems	☐ Hypertension	☐ High Cholesterol

☐ Other (Specify):

Allergies: _____

_____

Current Medications: _____

_____

_____

Social History:

Tobacco (Specify Type): ☐ Yes ☐ No Packs Per Day: _____

Alcohol: ☐ Yes ☐ No Amount: _____

Recreational Drugs (Specify Type): ☐ Yes ☐ No Amount: _____

Job/Profession: _____

Sexually active: □yes □no Sexual Partners: □male □female

Menstrual History: Onset (age)_____

Number of Pregnancies:_____ Miscarriages:_____ Abortions:_____ Children:_____

Past Surgical History:

Surgery	Reason	Year	Hospital
1.			
2.			
3.			
4.			
5.			

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Name:_____ Date of Birth:_____

Family History: Please check any that apply.

- ☐ Thyroid
- ☐ Hepatitis
- ☐ Migraines
- ☐ Other (Specify):
- ☐ Asthma
- ☐ Heartburn
- ☐ Lung Disease
- ☐ Back Pain
- ☐ High Cholesterol
- ☐ Obesity
- ☐ Mental Illness
- ☐ Seizures
- ☐ TB

	Alcoholism	Arthritis	Depression	Cancer (List type)	Diabetes	Genetic Disease	Heart Disease	High Blood Pressure	Osteoporosis	Stroke
Mother										
Father										
Siblings										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

- ☐ Adopted (Unknown)

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Receipt of Privacy Practices/HIPAA Regulation

Steinmann Family Health Clinic reserves the right to modify the privacy practices outlined in the notice.

HIPAA guidelines can be found attached to the clipboard. If you would like a copy of the information, please inform the front desk.

I have read/received a copy of the privacy practices and HIPAA regulations for Steinmann Family Health Clinic.

Name (print):_____

Signature of Patient/Guardian:_____

Relationship to Patient:_____