



Patient Registration (please print clearly)

Care Central Douglas Greater Glendale Illinois Valley Rogue Shady Cove

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Date of Birth: _____ Birth Sex: Male Female

SSN: _____ Driver License #: _____

Preferred Language: _____ Would you like a medical interpreter scheduled for all visits? Yes No

I identify as: Female Female-to-Male Transgender Non-Conforming
 Male Male-to-Female Transgender Decline to answer
 Other: _____ African American
_____ Decline to answer

Race: Asian American Indian or Alaska Native Decline to answer
 White Native Hawaiian/Other Pacific Islander African American
_____ Decline to answer

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to answer

Marital Status: Single Married Divorced

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Home Work Cell Email: _____

Secondary Phone: _____ Home Work Cell

Preferred Pharmacy: _____ Appointment Reminders OK? Yes No

Ok to leave message on: Home? Yes No Work? Yes No Cell? Yes No

Emergency Contact: _____ Phone: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Employee: _____ Phone: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

Primary Insurance: _____ Policy #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize AllCare Health Group to provide my insurance companies with all information necessary to process insurance claims and assign payments to AllCare Health Group all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. I have read and understood all of the above.

Signature: _____ Date: _____



Authorization for Communication of Protected Health Information to Family and Friends

Patient Name

Date of Birth

Home Phone Number

Cell Phone Number

Address

City

State

Zip

I, _____, authorize AllCare Medical Group to discuss/share my protected health information with the following individual(s):

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Type of information to be shared or disclosed:

<input type="checkbox"/> Appointment Information	<input type="checkbox"/> Medical Information	<input type="checkbox"/> Prescription Information
<input type="checkbox"/> Mental Health Information	<input type="checkbox"/> Lab/Imaging Results	<input type="checkbox"/> Any Information

I do not authorize AllCare Medical Group to share my protected health information with any individuals.

I authorize AllCare Medical Group to leave detailed messages about my medical and health information on the following:

<input type="checkbox"/> Cell Phone Voicemail	<input type="checkbox"/> Home Phone Voicemail
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Signature: _____ Date: _____

(This authorization shall remain in effect until revoked by the patient or for 1 year. You may request a new form at any time. Submitting a new form will replace the existing form.)



Health History

Patient Name: _____ Date of Birth: _____

Who was your last primary care provider? _____

Please list other Health Care Providers or Specialists you are currently seeing as a patient:

Are there any problems you specifically want to address?

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR THE FOLLOWING

<input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> Esophageal/GERD	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Angina/Heart Attack	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Excessive Snoring/Sleep Apnea	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Deaf/Hearing Issues	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Painful Menses
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dementia	<input type="checkbox"/> Heart Valve Problems	<input type="checkbox"/> Prostate Enlargement
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Clots Location: _____		<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Blind/Vision Issues	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV	<input type="checkbox"/> Migraine
<input type="checkbox"/> Cancer Type: _____		<input type="checkbox"/> Irritable Bowel Syndrome (IBS)	

Other health problems:



allcare Medical Group

Health History (continued)

MEDICATIONS

Do you have any trouble taking any of your medications? Yes No

ALLERGIES

Allergies (<i>environmental, food, drug</i>)	Reaction (<i>symptoms</i>)

FAMILY HISTORY

Father (Living: Yes No) Age: _____ Health: _____

Mother (Living: Yes No) Age: _____ Health: _____

Brother/Sister (Living: Yes No) Age: _____ Health: _____

Brother/Sister (Living: Yes No) Age: _____ Health: _____

Children How Many: _____ Age: _____ Health: _____

PREVIOUS SURGERIES (if additional surgeries attach an additional sheet of paper)

1 _____

Date of Last Colonoscopy: _____ Date of Last Bone Density: _____



Health History (continued)

Women Only

First menstrual cycle (age) _____ Present form of birth control _____

Date of last menstrual cycle _____ # of pregnancies _____ Full-term _____ Live births _____

Date of last mammogram _____ Date of last pap smear _____

LIFESTYLE

Occupation: _____

Married Status: Single Married Divorced Separated Domestic Partnership Widowed

Caffeine: How much caffeine do you consume per day? (e.g. coffee, tea, chocolate, soda) _____

Alcohol

How many drinking days do you have per week? _____ On average, how many drinks per drinking day? _____

Are you or others concerned about your drinking? Yes No

Tobacco and Vape Use

Do you currently use any forms of tobacco or do you vape? (please specify what type) _____

If yes, how frequently is your usage? _____ Are you interested in quitting? Yes No

Drug Use

Do you have a history of Drug use? Yes No (if yes, what substance) _____

Exercise/Activity

What Type of Exercise do you do (example: walking, swimming, running)? _____

How long? _____ How often? _____

Falls

Have you fallen in the past year? Yes No

Do you have problems with walking or balance? Yes No

Safety

Are you in a relationship that makes you feel unsafe or have been hurt? Yes No

Do you regularly wear a seatbelt? Yes No

HIV Testing

Would you like HIV testing? Yes No (If yes, please tell the Medical Assistant). HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.

Hepatitis C Testing

Have you ever been tested for Hepatitis C? Yes No

The United States Preventative taskforce recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years at least once in a lifetime.



Review of Symptoms

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE PAST TWO WEEKS?

Constitutional Symptoms

- Fever
- Weight loss
- Extreme fatigue

- Abdominal pain
- Constipation
- Diarrhea
- Blood in stools

Musculoskeletal

- Joint pain
- Muscle weakness

Eyes

- Double vision
- Sudden loss of vision

Genitourinary

- Irregular menses
- Bloody urine
- Vaginal bleeding after menopause
- Frequent or painful urination
- Impotence

Psychiatric

- Depression
- Anxiety
- Suicidal thoughts

Ears, Nose, Mouth, and Throat

- Sore throat
- Runny nose
- Ear pain

Skin

- Rash
- Changing Mole

Endocrine

- Excessive thirst
- Cold or heat intolerance
- Breast mass

Cardiovascular

- Chest pain
- Palpitations

Sleep

- Snoring
- Difficulty sleeping

Hematologic

- Unusual bruising or bleeding
- Enlarged lymph nodes

Respiratory

- Cough
- Wheezing
- Shortness of breath

Neurological

- Headache
- Persistent weakness on one side of the body
- Falling

Allergic

- Hay fever

Gastrointestinal

- Nausea
- Vomiting

IF YOU HAVE ONE OF THE FOLLOWING CONDITIONS PLEASE ANSWER:

Diabetes

Any problems with medications? Yes No Home glucose readings: _____

High Blood Pressure

Any problems with medications? Yes No Home blood pressure readings: _____

High Cholesterol

Any problems with medications? Yes No

Depression

Any problems with medications? Yes No Any suicidal thoughts? _____



Review of Symptoms *(continued)*

Please identify any issues on this form which are new or that you specifically want to address:

If you need help between appointments, please call your office location.

Our goal is to see you the day you call in or the next day. It is helpful if you call first thing in the morning. One of our nurses will help you decide if you need to be seen and if any tests are needed prior to your appointment.