



**COTTONWOOD MEDICAL CENTER, Ltd
ADULT PATIENT REGISTRATION FORM**

Last Name: _____ First Name: _____ Date of Birth: _____

Gender M F Marital Status: S M D W Social Security #: _____

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

Home Phone #: () _____ Work Phone #: () _____ Ext. #: _____

Name of Employer: _____ Occupation: _____ Phone #: () _____

Spouse's Name: _____ Date Of Birth: _____ Social Sec. #: _____

Spouse's Employer: _____ Phone #: () _____ Ext.: _____

Emergency Contact _____ Phone #: () _____ Ext.: _____

Individuals allowed release to discuss my medical history/records/results: _____

INSURANCE INFORMATION

Insurance Company: _____ Effective Date: _____

Identification #: _____ Group #: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

Do you have secondary insurance? **Yes** **No**

Insurance Company: _____ Effective Date: _____

Identification #: _____ Group #: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

**The following person (s) have permission for disclosure & pick up of my medical records in my absence.
MUST HAVE PROPER ID.**

Name: _____ **Name:** _____

Signature: _____ **Date:** _____

Financial Agreement

I have read and agree to abide by Cottonwood Medical Center's financial policy. If the account is sent to an attorney for collection, I agree to pay attorney's fees and collection expenses. The amount of the attorney's fees shall be established by the court and not by a jury in any court action. A delinquent account may be charged interest at the legal rate.

If any signer is entitled to medical benefits under any policy insuring the patient or any other party liable to the patient, the benefits are hereby assigned to Cottonwood Medical Center, Ltd. for application towards the patient's account. However, it is understood that **THE PATIENT AND/OR THE UNDERSIGNED ARE RESPONSIBLE FOR THE PAYMENT OF THE PATIENTS ACCOUNT.**

Signature: _____ Date: _____

Witness: _____ Date: _____

NAME: _____ M / F DATE OF BIRTH: _____

TODAY'S DATE: _____

PERSONAL HISTORY

Current Medications (incl. Over the Counter and supplements)	DOSE/STRENGTH	TIMES PER DAY
1.		
2.		
3.		
4.		
5.		
6.		

ALLERGIES (Medicine/Food):

Medication or Food Allergic To	Reaction

Current/Past Occupations/Retired: _____

Marital Status: Married/Committed Widow Divorced Single

Religious Affiliations: _____

PREVIOUS CONDITIONS/Diagnoses

	YES	NO		YES	NO	OTHER CONDITIONS	DATE
HAY FEVER			STOMACH TROUBLE, ULCER				
HEADACHES			THYROID TROUBLE				
HEART TROUBLE			TUBERCULOSIS				
HEMORRHOIDS			VARICOSE VEINS				
HERNIA			SEXUALLY TRANSMITTED DISEASE				
HIGH BLOOD PRESSURE							
HEPATITIS JAUNDICE							

PREVIOUS SURGERIES/HOSPITALIZATIONS:

Past Surgery or Hospitalization	Date

DATE OF LAST:

Tetanus Shot _____

Pneumonia Shot _____

Hepatitis B Shot _____

TB test _____

Colonoscopy _____

EKG _____

NAME: _____ M / F DATE OF BIRTH: _____

TODAY'S DATE: _____

CURRENT CONCERNS	YES	NO		YES	NO
ABDOMINAL PAIN			FREQUENT URINATION		
BLOOD IN STOOL			FREQUENT TROUBLE SLEEPING		
CHEST PAIN			HEADACHES		
CHILLS, FEVER			HEARTBURN		
CHRONIC COUGH			INDIGESTION		
COUGHING UP BLOOD			LOSS OF APPETITE, CHRONIC		
DIARRHEA			NIGHT SWEATS		
DIFFICULTY SWALLOWING			NUMBNESS		
DIZZINESS			PALPITATIONS		
EAR, NOSE, THROAT TROUBLE			RECENT WEIGHT GAIN OR LOSS		
EYE TROUBLE			SHORTNESS OF BREATH		
FAINING			SWELLING OF ANKLES OR FEET		
FATIGUE			WEAKNESS		

HABITS: Do You Now Or Have You Ever Consumed:

Cigarettes/Tobacco: Current User Quit Packs/ Day _____ # of years _____

Alcohol Wine Beer Liquor Drinks/Week _____

Coffee/Tea/Soda Cups/Day _____

Drugs (Marijuana, Meth, etc.) Type _____

Do you Exercise? _____ Hours/wk _____

Wear a seatbelt? Y / N Wear a helmet? Y / N Have smoke detectors? Y / N

FAMILY HISTORY:

Please list medical problems of blood relatives (parents, siblings, aunt/uncles) such as High Blood Pressure, Stroke, Heart attack, Diabetes, Cancer and type, Depression, etc. If anyone has died, please list age and cause of death if known.

Family Member	Age (Died)	Cause of Death or Medical Issues
Father		
Mother		
Sibs:		
Children:		

Women's Health:

No of Pregnancies: _____

LMP: _____

Year of Last :

PAP: _____

No. of Births: _____

Birth Control? Y / N

Mammo: _____

No. of Abortions/Miscarriages: _____

STD hx? Y / N

Breast exam: _____