New Patient Registration Questionnaire

Today's Date: _____

Patient: _____ _____ _____
Last MI First

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ ***Preferred # to Contact: Home / Work / Cell (Circle One)***

Can we leave a message on the preferred #? Yes / No

Sex: F / M Date of Birth: _____ Marital Status: Single / Married / Divorced / Widowed / Separated

Email: _____ ***Can we send you office newsletters or other correspondence? Yes / No***

Occupation: _____

In case of emergency, notify: _____ Phone: _____

Name of Your Medical Insurance: _____ Telephone: _____
Address: _____

Primary Insured's Name:_____ DOB: _____

Primary Physician with Contact Information: _____

Dentist with Contact Information: _____

Who Referred You to Dr. Moncada? _____

Your Pharmacy: _____ Telephone: _____

City: _____ State: _____

I have read the "Office & Financial Policies" & "Notice of Privacy Practices", which details Dr. Elizabeth Moncada's HIPAA Compliance.

_____ _____
Signature **Date**

"PRIVATE AND CONFIDENTIAL-WITHOUT PREJUDICE-NOT FOR PUBLICATION."

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PRIVATE AND CONFIDENTIAL

HEALTH HISTORY

Reason for today's visit: _____

_____

Address: _____ Telephone: _____ Fax: _____

Please Attach Names and Contact Information for other Practitioners seen for this condition.

_____

Do you have any of the following medical conditions?

• Seizure Disorder	YES / NO	Rheumatologic Disorder	YES / NO
• Stroke	YES / NO	Hiatal Hernia	YES / NO
• Cataracts	YES / NO	Muscle / Bone Disease	YES / NO
• Glaucoma	YES / NO	HIV/Hepatitis (circle)	YES / NO
• High Cholesterol	YES / NO	Acid Reflux	YES / NO
• Asthma	YES / NO	Anemia	YES / NO
• High Blood Pressure	YES / NO	Bleeding Disorder	YES / NO
• Heart Disease/Heart Attack	YES / NO	Angina	YES / NO
• Head and Neck Problems	YES / NO	Thyroid Disorder	YES / NO
• Depression	YES / NO	Sleep Apnea	YES / NO
• Anxiety	YES / NO	Headaches	YES / NO
• Breast Disease	YES / NO	Diabetes	YES / NO
• Weight Loss / Loss of Appetite	YES / NO	Cancer (including skin)	YES / NO
• Sweats / Chills	YES / NO	Insomnia	YES / NO
• Numbness / Tingling	YES / NO	Fever	YES / NO
• Emphysema	YES / NO	Arthritis	YES / NO

- Change In Vision / Smell / Taste / Swallowing / Hearing (Circle what applies)
- Jaw Issues /Pain and/or Limited Jaw Function / TMJ Noises / Decreased Jaw Range of Motion / Change In Bite
- Sleep Issues/Insomnia/Trouble Falling Asleep/Trouble Staying Asleep/Morning Headache or Jaw Pain/Snoring

Allergies: _____

Previous Surgeries: _____

Medications (including herbs, vitamins, over the counter drugs): _____

_____

Comments (Anything else that might help us understand your illness): _____

_____

_____ _____

Patient Signature ***Date***

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