Dr. David J. Silverstein Associates
GENERATIONS OF CARE FOR OVER 50 YEARS

Patient Registration Form

Patient Information

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (☐ Cell or ☐ Work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/_____ Age: _____ Sex: M F Social Security Number: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient's Employer: _____ Employment Status: [ ] Full time [ ] Part time [ ] Unemployed
[ ] Retired [ ] Student [ ] Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

Race [ ]Asian [ ] Black or African American [ ] Native American [ ] White / Caucasian [ ] Other: _____

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: _____

Number of children: _____ Children's Names/Ages: _____

Insurance Information

Primary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

Medical Information

Please list any MEDICATIONS you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

Preferred **Pharmacy**: _____

Date of Last Complete Physical Exam: _____ Date of Last Blood Work: _____

Date of Last Colonoscopy: _____ Date of Last Tetanus Shot: _____

For Females: Date of Last Menstrual Period: _____ Date of Last Pap Smear: _____

History of Abnormal Pap (list date/s)? _____ Date of Last: Mammogram: _____ DEXA: _____

Number of Pregnancies: _____ Miscarriages: _____ Terminations: _____ Living Children: _____

Method/s of Contraception: _____

If **YOU** or a **FAMILY MEMBER** has had any of the following, please circle and indicate which family member when applicable:

ADD/ADHD ☐
Anemia ☐
Allergies/Hay Fever ☐
Asthma ☐
Arthritis ☐
Anxiety/Depression ☐
Alcoholism ☐
Blood Clots ☐
Cancer, Type/s ☐

Respiratory Disease ☐
Skin Disease ☐
Stomach/Colon Disease Stroke ☐
Seizure Disorder ☐
Thyroid Disorder ☐
Sexually Transmitted Disease ☐

Other:

Please list any **SURGERIES** you have had and include the month/year:

_____

_____

_____

_____

Social Information

Tobacco Use: Do you smoke? _____ If so, how many cigarettes/cigars per day: _____ No. of years smoking: _____ Do you chew tobacco? _____ Have you thought about quitting? _____ Have you quit before? ____ How long?____

Alcohol Use: Do you drink alcohol? ____ If so, what type? _____ How many in 1 week? _____

Drug Use: Any history of illegal drug use? _____ If so, what type/s? _____ When? _____

Do you **exercise**? _____ What activities do you do, and how often in 1 week?_____

Do you consume any **caffeinated** products? _____ If so, what and how much per day? _____

Have you recently noticed an increase in sadness or gloominess? _____

Have you lost interest in enjoyable activities? _____

Do you have a living will? _____ If yes, please provide us a copy.

Scheduling Policy

Dr. Silverstein & Associates reserves the right to charge a fee for any scheduled visits that are missed without calling to cancel (no-show)

Patient / Parent or Guardian Signature: _____ Date: _____