Roanoke Medical Associates

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Williamston, NC 27892

Phone (252) 792-0022
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PATIENT REGISTRATION

APPT. DATE & TIME ---------- MEDICAL RECORD #

Last Name	First Name	Middle Initial	Race	Sex ( ) M ( ) F	Date of Birth

Social Security #	Marital Status M S D W	Home Phone # Cell Phone # Work Phone #	Referring/Family Physician Name:

Street Address/ P O Box #	City	State	Zip Code	Number of Children:

E-MAIL ADDRESS		Occupation/Retired/Disabled

Employers Name	Employer Phone Number

Name of Nearest Relative not living with you	Relative's Phone # Cell Phone #	Your Spouse's Name:

Spouse's Social Security #	Spouse's DOB / /	Work #	Cell Phone #

I hereby authorize my insurance benefits to be paid directly to Roanoke Medical Associates realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers and my referring physicians. I understand a late charge of 1.5% per month will be applied to all charges outstanding for more than 60 days.

Patient's Signature_____ **Date** _____

DO YOU HAVE INSURANCE? YES / NO ----- PLEASE MAIL A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE TO OUR OFFICE WITH THIS REGISTRATION FORM, OR YOU MAY BRING THEM WITH YOU, AT THE TIME OF YOUR VISIT WE WILL MAKE A COPY SO WE CAN FILE YOUR INSURANCE.

Medications- Please list **all** medications you are currently taking. Include all medications even **over the counter and vitamins**.

PHARMACY NAME & PHONE NUMBER INCLUDING AREA CODE: _____ **---**

Drug Name	Dosage (mg)	Frequency (times per day)

***CONTINUE TO NEXT PAGE ***

Chief Complaint and Present Illness

Do you have any of the following

( ) History of Smoking ( ) Currently Smoking ( ) Hypertension ( ) Diabetes ( ) High Cholesterol
( ) Family history of heart disease

Reason for Consultation:

( ) Abnormal EKG ( ) Chest Pain/Tightness ( ) Fainting ( ) Heart Attack
( ) Heart Failure ( ) High Blood Pressure ( ) Irregular /Rapid Heart Rate ( ) Shortness of Breath
( ) Positive Stress Test ( ) Consultation ( ) Surgery Clearance ( ) Other_____

List All Symptoms: _____

Date Symptom(s) Began: _____Frequency of Symptom(s): _____

What brings it on: _____What makes it worse: _____

What relieves it: _____Associated Symptom(s): _____

Review of Systems: Please check only the ones you NOW have or have had recently.

GENERAL	SKIN	HEENT
( ) WEAKNESS	( ) NAIL CHANGES	( ) BLURRED VISION
( ) FATIGUE	( ) BRUISING	( ) VISUAL DISTURBANCES
( ) CHILLS	( ) RASHES	( ) VERTIGO (DIZZINESS)
( ) NIGHT SWEATS	( ) EXCESSIVE SWEATING	( ) EAR PAIN
( ) FEVER	( ) ITCHING	( ) VOICE CHANGES

NECK	LUNGS	HEART
( ) NECK PAIN	( ) COUGHING BLOOD	( ) PALPITATIONS
( ) NECK MASS	( ) COUGH	( ) CHEST PAIN
( ) NECK STIFFNESS	( ) WHEEZING	( ) FAINTING
( ) SWOLLEN GLANDS	( ) DIFFICULTY BREATHING	( ) SWELLING
		( ) SHORTNESS OF BREATH

GASTROINTESTIONAL	MUSCULOSKELETAL	NEUROLOGICAL
( ) ABDOMINAL PAIN	( ) MUSCLE CRAMPS	( ) SEIZURE
( ) NAUSEA	( ) JOINT PAIN	( ) VERTIGO
( ) VOMITING	( ) LEG CRAMPS	( ) DIZZINESS
( ) HEARTBURN	( ) CALF PAIN	( ) SYNCOPE
( ) CONSTIPATION	( ) MUSCLE TWITCHING	( ) UNSTEADINESS
( ) DIARRHEA		
( ) DIFFICULTY SWALLOWING		

PSYCHIATRIC	ENDOCRINE	HEMATOLOGY
( ) CHANGES IN SLEEP	( ) COLD INTOLERANCE	( ) ANEMIA
( ) DELUSIONS	( ) APPETITE CHANGES	( ) EASY BRUISING
( ) EARLY AWAKENINGS	( ) HAIR CHANGES	( ) GLAND PROBLEMS
( ) HALLUCINATIONS	( ) HEAT INTOLERANCE	( ) RED SKIN SPOTS
( ) SUICIDAL THOUGHTS	( ) EXCESSIVE DRINKING	( ) BLEEDING

LIST ALLERGIES:_____

_____

_____

SOCIAL HISTORY

Who do you live with?_____
Does anyone assist you with daily activities? Yes No

ASSISTIVE DEVICES: ( ) Walker ( ) Cane ( ) Wheelchair ( ) None

ALCOHOL: ( ) Never ( ) Beer(s) per week: _____ ( ) Liquor per week _____ ( ) Wine per week _____
How Many years_____

SMOKING: ( ) Never ( ) Current ( ) Packs per Day _____ How many Years_____
( ) Previous When Quit_____

Past Medical History – please list all surgeries and medical conditions	Date

FAMILY HISTORY	Age	Cause of Death	Illnesses
Father			
Mother			
Brothers			
Sisters			
Others			

*****RETURN TO THE RECEPTIONIST*****