



Shore Medical Center at Metompkin

... a division of Shore Health Services, Inc.®

PATIENT REGISTRATION

Please fill out this information on the patient. We will make copies of your insurance card(s).

Name: _____ Single / Married / Widowed / Divorced

911 address: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Home phone: () _____ Cell phone: () _____

Gender: M / F Birth date: _____ Age: _____

Social Security #: _____

Your occupation: _____

Your employer: _____

Employer's address: _____

City: _____ State: _____ Zip: _____

Employer's phone: _____

Spouse's name: _____ Spouse's phone: _____

Spouse's employer: _____ Spouse employer ph: _____

Who is responsible for your medical bills? Self / Employer / Other (if 'other', please provide information below):

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

If you are covered under your spouse's insurance, please list policyholder's name, DOB, and ID#:

Who should we contact in case of emergency or if we can not reach you?

Name: _____ Relationship to you: _____

Daytime phone: _____ Evening phone: _____

Are you allergic to any medications? ___YES ___NO

If 'Yes', please specify: _____

Any other allergies? ___YES ___NO If 'Yes', please specify: _____

Do you have an Advance Directive? ___YES ___NO

Would you like information on Advance Directives? ___YES ___NO

Shore Medical Center at Metompkin has my permission to

discuss my medical information with: _____ (Name / Relationship)

leave messages on answering machine and/or with family members: ___YES ___NO

Other (please specify): _____

What pharmacy do you use? _____



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MEDICAL HISTORY

If you are currently taking any medications, please list them here: _____

Please list any surgeries you have had: _____

| DO YOU HAVE A HISTORY OF: | YES | NO |
|----------------------------------|-----|----|
| HEADACHES / DIZZINESS | | |
| DOUBLE / BLURRED VISION | | |
| NOSE BLEEDS | | |
| EAR ACHES | | |
| HARD OF HEARING | | |
| SEIZURES | | |
| CHRONIC COUGH | | |
| SORE THROAT | | |
| ASTHMA | | |
| SHORTNESS OF BREATH | | |
| CVA / STROKE | | |
| HIGH BLOOD PRESSURE | | |
| DIABETES | | |
| CHEST PAIN | | |
| NAUSEA / VOMITING | | |
| CONSTIPATION | | |
| DIARRHEA | | |
| URINARY FREQUENCY | | |
| HISTORY OF ULCER | | |
| BLOOD IN YOUR STOOL | | |
| NERVOUS ILLNESS | | |
| ANXIETY | | |
| DEPRESSION | | |
| UNEXPLAINED / RECENT WEIGHT LOSS | | |
| CANCER | | |

| DO YOU HAVE A FAMILY HISTORY OF: | YES | NO |
|---|-----|----|
| HEART DISEASE | | |
| ARTHRITIS | | |
| DIABETES | | |
| CVA / STROKE | | |
| HIGH BLOOD PRESSURE | | |
| NERVES / ANXIETY | | |
| ASTHMA | | |
| CANCER | | |
| THYROID PROBLEMS | | |
| OTHER: | | |
| DO YOU SMOKE? | | |
| If so, number of packs per day: _____ | | |
| Quit date: _____ | | |
| DO YOU DRINK ALCOHOLIC BEVERAGES? | | |
| (circle one) Never, Occasional, Moderate, Heavy | | |
| When was your last Tetanus vaccine? _____ | | |
| When was your last eye exam? _____ | | |
| Ophthalmologist/optometrist? _____ | | |
| Who is your dentist? _____ | | |
| For Women only: | | |
| # of pregnancies: _____ | | |
| # of children: _____ | | |
| Date of last PAP test? _____ | | |
| Date of last mammogram? _____ | | |

AUTHORIZATION FOR TREATMENT: I hereby give permission to the health care providers of Shore Medical Center at Metompkin and any assistants to administer treatment, medication or diagnostic testing that they may deem advisable in the care and treatment of my case. Authorization is given to Shore Medical Center at Metompkin and any assistants to contact the patient's employer or insurer regarding existing coverage of patient's insurance(s). I understand that Shore Medical Center at Metompkin will release financial, medical and other such information in accordance with Federal Law (HIPAA) as explained in the Patient Notice of Privacy Practices booklet. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Shore Medical Center at Metompkin and of my rights with respect to my health information.

____ I have received. ____ I have been offered and refused.

Briefly explain why the patient was not able or willing to sign this form: _____

Patient or Responsible Party Signature: _____ Date: _____

I authorize the release of any medical information necessary to process insurance claims and request that payment of benefits be made to Shore Medical Center at Metompkin. I understand that if I am referred to another doctor or for diagnostic testing, it is my responsibility to obtain an insurance referral. I understand that I am financially responsible for all charges for services rendered by the health care provider. Even though I may carry health insurance, I understand that I will be responsible for any charges that are not covered by my health insurance policy. I understand that my co-pay is to be paid at the time of service.

Patient or Responsible Party Signature: _____ Date: _____