



Patient Registration Form

Who referred you to Dr. Romanelli: _____

Last Name: _____ First Name: _____

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

Phone Home: _____ Phone Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Sex: Male Female SS#: _____

Marital Status: Married Single Divorced Widowed Separated

Emergency Contact: Name _____ Phone Number _____

Occupation: _____ Employer: _____ Employer Address: _____

Responsible Party:

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

Phone Home: _____ Phone work: _____

Insurance Plan Information: Primary

Insurance Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Policy Holder:

Name: _____ Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____ Phone Home: _____ Address: _____

Employer: _____ Phone Work: _____ Address: _____

Secondary Insurance:

Insurance Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

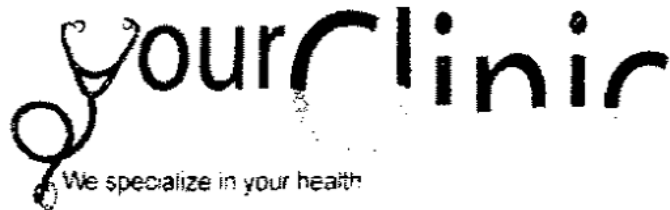
Policy Holder:

Name: _____ Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____ Phone Home: _____ Address: _____

Employer: _____ Phone Work: _____ Address: _____

Signature: _____ Date: _____



Medical History

Last Name: _____ First Name: _____ D.O.B: ____/____/____

Check all that apply:

Drug Allergies: _____ **Reaction:** _____

Non-Drug Allergies: _____ eggs _____ tape _____ IPV Dye _____ seafood other: _____

Childhood Illnesses: _____ None significant _____ ADD _____ Asthma _____ Eczema
 _____ Nasal allergies Other: _____

Adult Illnesses:

	Diagnosis date
Arthritis	____/____/____
Asthma	____/____/____
Bipolar Disorder	____/____/____
Cancer Of _____	____/____/____
Stroke	____/____/____
Depression	____/____/____
Diabetes	____/____/____
High Cholesterol	____/____/____
GERD/Heartburn	____/____/____
Gestational Diabetes	____/____/____
Glaucoma	____/____/____
Headaches	____/____/____
Heart Attack	____/____/____
Heart Disease	____/____/____
CHF/Heart Failure	____/____/____
High Blood Pressure	____/____/____
Thyroid Disease	____/____/____
Pneumonia	____/____/____
Osteoporosis	____/____/____
Other: _____	____/____/____

Hospitalizations
(year : illness)

Surgeries

Prescribed Medicatons

Non Prescriptions Medications

Health Maintenance/Prevention

When was the last done taken or the last test performed?

Cholesterol	____/____/____
Prostate/Rectal Exam	____/____/____
PSA	____/____/____
Mammogram	____/____/____
Dexa Scan/Osteoporosis	____/____/____
Pap Smear	____/____/____
Pneumonia (pneumovax)	____/____/____
Colon Screening	____/____/____

Flu Vaccine	____/____/____
Tetanus	____/____/____
Hepatitis B(3 shots)	____/____/____
TB test/PPD	____/____/____

What Colon test was done?

Flex Sigmodiscopy:	When: ____/____/____
Colonoscopy:	When: ____/____/____
Stool Cards:	When: ____/____/____

CONTINUE SECOND PAGE

Your Clinic

We specialize in your health

Social History:

Marital Status _____
 Occupation _____
 Alcohol Consumption _____
 None / Never a heavy drinker _____
 Past heavy drinker but quit _____
 Drink socially _____
 *How many drinks (or beers) per day? _____
 *How many days per weeks do you drink? _____
 Tobacco consumption _____
 None / Never _____
 currently smoke _____
 *How many packs per day? _____
 *How many packs per week? _____
 I live with a smoker _____
 quit smoking #of years ago _____
 *If you quit smoking, how many packs per day
 did you smoke and for how many years?
 _____ packs per day for _____ years

Family History:

Mother's history _____
 Healthy _____
 Deceased due to _____
 Significant for:
 _____ Diabetes :She developed it at the age of _____
 High Blood pressure _____
 Cancer of the _____
 She developed it at the age of _____
 Stroke _____
 Depression _____
 Bipolar disorder _____
 Glaucoma _____
 Cholesterol abnormality _____
 Osteoporosis _____
 Thyroid disease _____
 Heart disease _____
 Other relatives with significant disease _____
 Relationship:

Substance Abuse / Illegal drug use

None / Never _____
Illegal Drugs used in the past / recovered
 Patient Admits to: Frequency?
 Marijuana _____ Frequently _____
 Cocaine _____ Infrequently _____
 Intravenous drug use Rarely _____
 Narcotics _____
 Amphetamines _____
 Anabolic Steroids _____

Exercise

Frequency? _____ Yes - _____ No
 Frequently _____
 Infrequently _____
 Rarely _____

Father's history _____
 Healthy _____
 Deceased due to _____
 Significant for:
 _____ Diabetes :He developed it at the age of _____

High Blood Pressure--- _____
 Cancer of the _____
 He developed it at the age of _____
 Stroke _____
 Depression _____
 Bipolar disorder _____
 Glaucoma _____
 Cholesterol abnormality _____
 Osteoporosis _____
 Thyroid disease _____
 Heart disease _____

Disease:



PF-3000 Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

___ all information in my files, or

Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

___ education, discussion of treatment plan, medical decision making, or

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

E.S. Romanelli, M.D., P.A.

Name of person/organization

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

Name of person/organization

Name of person/organization

Expiration Date of Authorization

This authorization is effective unless and until revoked by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to the practice. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

Rights of the Individual

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.

Effect of Refusing Authorization

If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

Treatment conditioned on authorization

Signature

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient: _____



PF-2000

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient