Patient Registration Form

Last name: **First name:** **Middle:**			Today's date
Social Security Number		Marital Status: Single Married Divorced Separated	
Birth date: / /	Age:	Sex: ❑ M ❑ F	
Email	**Cell phone** ( )	❑Home ❑Work ( )	
Address	City	State	Zip Code
Employment status: Employed Unemployed Retired Student	Occupation	Company	Preferred Language
How did you find us? Website ____ Friend ____ Family ____ Insurance_____ Other_____			
Can we forward your lab result to? _____Phone _____Emergency contact			
Year of most recent: Colonoscopy (if >50yr) _____; Bone Density (if >65yr) _____ **Women ONLY**: Date of Pap smear _____ Any abnormal result? Yes/No Mammogram _____			
Year of Vaccination: Flu _____ Tetanus _____ HPV _____ Shingles _____ Pneumonia _____			
Pharmacy name: Address:			
Emergency: Relationship: Phone: ( )			

FINANCIAL AND OFFICE POLICES

Please check each polices to indicate you read EACH statement:
___ 1. I agree to receive service and treatment from this facility
___ 2. I authorize my insurance carrier, attorney, or any third-party payer to pay directly to Bay Area Union Health Center for service rendered.
___ 3. I authorize the release of any information required to process my claims or as required by law.
___ 4. I will provide the most recent personal information and insurance information.
___ 5. I understand coverage and cost of lab or other diagnostic tests ordered during office visits and annual preventive exam is subject to my insurance plan. Insurance only pays for covered items when certain criteria are met, the fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason that it is recommended. For detailed benefit explanation, I could consult my insurance company before the tests are done. If not covered, I will be responsible for these charges.
___ 6. I will inform BAUHC if there is any change in my allergy, surgical, social or family history etc.
The above information is true to the best of my knowledge. I acknowledge that I have received, read and understand the Financial and Office Policies of Jie Ling, M.D., Ph.D.

Name: _____ Birth Date: _____

ALLERGIES

PAST SURGERIES AND HOSPITALIZATIONS

Year	Type of Surgery	Reason	Outcome

FAMILY HISTORY

	Age	Health	Heart disease	Blood pressure	Cancer	Stroke	Diabetes	Other
Father								
Mother								
Siblings								
Child								

SOCIAL HISOTRY

___ Tobacco use	___ Alcohol use	___ Drug use
___ Caffeine use	Diet	Immigration date to US
Sexual preference	Religion	Exercise

Who do you live with?	**Relationship**

CURRENT MEDICATION

Name of medicine:	Dose/How the medicine is taken:
Nutritional supplements currently taking:	

Name: _____ Birth Date: _____