QUILICI/TOVAR SURGICAL GROUP
PATIENT REGISTRATION FORM

Today's Date:		PRIMARY CARE PROVIDER :	
PATIENT INFORMATION			
Last name: First:		Middle:	
Marital status:	Birth date:	Age:	Sex: MALE / FEMALE
Address:			
Social Security no.:	Home phone no.:		Cell phone no.:
Occupation:	Employer:		Employer phone no.:

Chose clinic because/referred to clinic by (Please choose one option):

- ○ DOCTOR'S REFERRAL
- ○ PATIENT REFERRAL

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:
Patient's relationship to subscriber:			

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber:			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize QUILICI/TOVAR SURGICAL GROUP or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions:

_____

_____

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

_____

_____

_____

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Medication	Dosage & frequency

Medication allergies:

Preferred Pharmacy:
Address & Phone Number:
