Patient Registration
Mary Ella Carter, MD, FACS

I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

Patient Signature **Date**

Patient Information			
Patient Name: (Last)	(First)		(MI)
Social Security #	☐Female ☐Male	Date of Birth Age	Marital Status M W D S
Street Address		Home Phone	
City		Work Phone	
State ZIP		Cell Phone	
Bill to Name		Fax	
Billing Address		E-mail	
City		Emergency Contact Name	
State ZIP		Emergency Contact Phone	
Employment Information		Employer Name	
Occupation		Employer Phone	

Referring and Primary Care Physician Information			
Referring Doctor Name		Primary Care Doctor Name	
Street Address		Street Address	
City		City	
State ZIP		State ZIP	
Phone		Phone	
Fax		Fax	
Pharmacy	Name	Phone	Fax
Primary Insurance		***Secondary Insurance***	
Company		Company	
Group #		Group #	
ID #		ID #	
Policy Holder Name	date of birth	Policy Holder Name	date of birth

Mary Ella Carter, MD, FACS

Health History
New Patient

I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

_________________________ _________________________

Patient's Name (Print: First Middle Last) ***Patient's Signature*** ***Date***

Date of Birth		**Referring Physician**	

Reason for your visit today

Immunizations:

Influenza (flu): _________ Pneumovax (pneumonia): YES / NO Tdap (tetanus): _________

Medications: list ALL that you are currently taking	**Allergies: list ALL medications and foods allergies**
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10	**Allergy to latex ☐ yes ☐ no**
☐ **I take no medications currently.**	☐ **I have no known allergies.**

List **ALL** prior **operations or surgeries** you have had (included dates if known)
☐ **I have not had any surgery in the past.**

List **ALL** your **Diagnosed Medical Problems** _(not just those related to your current office visit)_
☐ **I have no known medical problems.**

Patient Name________________________________ Date______________

Please answer the following questions	✔ yes	✔ no
Do you smoke cigarettes?		
If so, how many packs per day?		
Former Smokers: Year Started/Year Finished		
Do you smoke a pipe or cigars?		
Do you dip snuff or chew tobacco?		
Do you drink alcohol?		
How often and how much alcohol do you drink?		
Do you use any street drugs?		
If so, which drugs do you use?		

Cancer History (Personal/Direct Family Member):

Breast Cancer: ____

Melanoma: ____

Skin Cancer(s): ____

Other: ____

REVIEW OF SYSTEMS (ROS) Please ✔ symptoms you currently have or have had in the past year

	General		***Eye, Ear, Nose, Throat***		***Musculoskeletal***		***Psychiatric***
	Fevers or Chills		Difficulty swallowing		Joint pains		Anxiety
	Dizziness		Hearing loss		Muscle aches		Depression
	Fainting spells		Hoarseness		Ankylosing spondylitis		Psychiatric hospitalization
	Fatigue		Nose bleeds		Weak bones		Panic attacks
	Frequent headaches		Ringing in ears		Rheumatoid arthritis		Suicidal thoughts
	Insomnia		Sinus problems		Osteoarthritis		Psychiatric drugs
	Sweats		Vision - blurred		Bone cancer		Memory loss
	Weight changes		Poor vision		Bone infections		Other:
	Other:		Other:		Other:		***MEN only***
	Cardiovascular		***Gastrointestinal***		***Genito-Urinary***		Breast lumps
	Ankle swelling		Poor appetite		Bladder control		Enlarged prostate
	Chest pains		Bowel changes		Blood in urine		Erectile dysfunction
	Enlarged heart		Constipation		Frequent urination		Penis discharge
	Heart attack		Diarrhea		Kidney stones		Prostate cancer
	Heart murmur		Excessive thirst		Painful urination		Other:
	Heart palpitations		Heartburn		Urgent urination		***WOMEN only***
	High blood pressure		Nausea		Weak stream		Abnormal Pap Smear
	Shortness of breath		Rectal bleeding		Other:		Breast Lumps
	Irregular heart beat		Stomach pain		***Neurological***		Vaginal discharge
	Prolonged bleeding		Ulcers		Loss of fine motor control		Severe menstrual pain
	History of blood clots		Vomiting		Weakness		Hot flashes
	Other:		Other:		Paralysis		Other:
	Endocrine		***Skin***		Poor balance	Date of last period:	
	Blood sugar problem		Bruise easily		Seizures	Age periods began:	
	Use of steroids		Foot ulcers		Speech difficulties	Age of menopause:	
	Over Active Thyroid		Rashes		Tremors	Are you pregnant?	
	Under Active Thyroid		Sores that won't heal		Muscle wasting	# of pregnancies:	
	Other:				Other:	# of live births:	

Date of Last Mammogram (Month/Year): ____________/____________

Result:____

By my signature below, I acknowledge:

- my receipt and acceptance of the *Notice of Financial Responsibility Practices of Dr. Mary Ella Carter* dated June 15, 2011.

And, when necessary in processing insurance claims for medical or surgical treatment or services rendered to me, I expressly authorize:

- the release of any medical information about me by any holder of said information to any insurance carrier, who may provide financial assistance for this treatment or service;
- the release to the Centers for Medicare and Medicaid and/or to the Health Care Financing Administration and its agent(s) of any medical information necessary to determine benefits;
- the payment by my insurance carrier(s) of insurance and/or Medicare benefits directly to Dr. Mary Ella Carter, MD, FACS

______________________	______________________
Patient Name (Print: First, Middle, Last)	*Patient Signature* *Date*

By my signature below, I acknowledge:

- access to the notices regarding company relationships, ancillary services and/or physician relationships;
- my receipt and acceptance of the Mary Ella Carter, MD, FACS *Notice of Privacy Practices* dated June 10, 2011.

Patient Name (Print: First, Middle, Last)	*Patient Signature*
Personal Representative Name (Print first, MI, Last)	*Personal Representative Signature*
Representative's Relationship to Patient	*Date*

Advanced Care Planning:

Do you have a health care proxy in the event you are unable to make your own medical decisions?

Yes ☐ **No** ☐

Designee's Name: ______________________

Designee's Phone Number: ______________________

Designee's Relationship to Patient: ______________________