Cedar Avenue
INTEGRATIVE MEDICINE

PATIENT REGISTRATION FORM

Today's Date

PATIENT INFORMATION

Name: | Date of Birth: | Age:

Gender: ☐ M ☐ F | Marital Status:

Address: | Phone (hm):

City/State/Zip: | Phone (cell):

Email: | May we leave messages at these numbers? ☐ H ☐ C

Preferred method of communication: ☐ Email ☐ Home phone ☐ Cell phone

Emergency Contact: Phone:

Their relationship to you:

For Minors Only: Name of Mother: Name of Father:

HOW DID YOU HEAR ABOUT US?

☐ Family/Friend ☐ Insurance ☐ Physician Referral

☐ Internet: Specify ☐ Other:

BILLING FORMATION

Is patient covered by insurance? ☐ Yes ☐ No | If No, Name of Person Responsible for Bill:

Primary Insurance: | *Address and Phone Number of Responsible Party (if different from above)

(PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Subscriber's Name Employer: Occupation: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

Secondary Insurance: Subscriber's Name Employer: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

☐ By checking this box, I am verifying that the above is true to the best of my knowledge.

Date: _____

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HEALTH HISTORY QUESTIONNAIRE *For Newborns*

All questions contained herein are strictly confidential and will become part of your child's medical record.

Form completed by:	**Date:**
Name: *(Last, First, M.I.)* ☐ **M** ☐ **F**	**DOB:**

BIRTH HISTORY

Prenatal history:	☐ YES ☐ NO	Gestational diabetes
	☐ YES ☐ NO	Group B Strep
	☐ YES ☐ NO	Hypertension
	☐ YES ☐ NO	Smoking during pregnancy
	☐ YES ☐ NO	Alcohol or recreational drug use during pregnancy

Birth History: ☐ Vaginal ☐ Cesarean Section ☐ Forceps ☐ Vacuum ☐ Trauma?
Timing: ☐ On time ☐ Before 37 weeks ☐ After 42 weeks

Birth site: _____ Birth Attendant: _____

Illness: Any newborn problems? ☐ Jaundice ☐ Hospitalization ☐ Other, describe

DIET AND ENVIRONMENT

Feeding Plans:

☐ Breastmilk only
☐ Formula
☐ Mixed

Home Environment:

How many children in your home? _____
This child's birth order (3rd of 4 kids…) _____
What adults live with your child? _____

☐ YES ☐ NO Does your home have adequate heat, a telephone and enough food?
☐ YES ☐ NO Was your home built before 1950?
☐ YES ☐ NO Does your home have mold?
☐ YES ☐ NO Is your home safe?

FAMILY HEALTH HISTORY

Is your child adopted? ..... ☐ Yes ☐ No

Has any family member (or you) been diagnosed with:	**YES**	**NO**	**Who? At what age?**	**Details**
Asthma	☐	☐		
Emphysema	☐	☐		
Severe allergies	☐	☐		
Thyroid problems	☐	☐		
Stroke/Blood clots	☐	☐		
Heart disease	☐	☐		
Heart attack	☐	☐		

High blood pressure	☐	☐		
High cholesterol	☐	☐		
Kidney disease	☐	☐		
Gallbladder disease	☐	☐		
Osteoporosis	☐	☐		
Liver disease	☐	☐		
Colitis/Crohn's/Celiac	☐	☐		
Anemia	☐	☐		
Blood disorder	☐	☐		
Diabetes	☐	☐		
Alcohol or drug problems	☐	☐		
Cancer	☐	☐		
Mental illness/depression	☐	☐		
Alzheimer's disease	☐	☐		
Deafness	☐	☐		
Developmental disability	☐	☐		
Bed-wetting after age 10	☐	☐		
Other:	☐	☐		