



The Crawford Clinic

1900 Leighton Avenue Suite 101 Anniston, Alabama 36207

Phone: 256-240-7272 Fax: 256-240-7242

Patient Registration Form

Today's Date: _____ SSN#: _____ Sex: male female

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: _____ Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email Address: _____

Marital Status: _____ Race or Ethnicity: _____

Referring doctor: _____ Office Phone#: _____

Primary Medical Doctor (if different): _____ Office Phone#: _____

#1 Insurance Co: _____ Policy# _____ Group# _____

Name of Policy Holder: _____ Relation: _____

Policy Holder DOB: _____ and SSN# _____

#2 Insurance Co: _____ Policy# _____ Group# _____

Name of Policy Holder: _____ Relation: _____

Policy Holder DOB: _____ and SSN# _____

Emergency Contact person: _____ Phone#: _____

List of persons to disclose protected medical information with:

I have received, read, understand, and agree with the Notice of Privacy Practices form and authorize The Crawford Clinic to release information pertaining to my medical care to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing this document I am stating that I or my patient representative have received, read, understand, and agree with all of the terms and information contained in the **Notice of Privacy Practices, Consent to Treatment, and Consent to Use and Disclose Protected Health Information** forms provided by The Crawford Clinic. I also agree that the statements above and answers on the Medical History and Review of System's sheet are true and complete to the best of my knowledge.

Signature of Patient

Name of Patient

Date

Signature of Patient Representative

Name of Representative

Date

Reason for Representation: _____

Medical History and Review of Systems

Past Medical

History: _____

Prior Surgery: (Please list type of surgery, date, and surgeon): _____

Allergies to Medications: _____

Medications: (Please list dosage amount and how often): _____

Smoke: yes or no---if yes, _____ packs per day for ___years Alcohol: _____drinks/week Illegal Drugs: yes or no

Review of Systems:

Circle all that apply to you currently:

Constitutional:

weight loss or gain
amount: _____
fever or chills

HEENT:

eye disease or cataracts
wear glasses/contacts
blurred vision
impaired hearing
constant ear ringing
sinus disease
frequent nose bleeds
sore throat
neck stiffness or pain
neck swelling

Cardiovascular:

heart attack
hypertension
coronary artery disease
carotid artery disease
chest pain or angina
atrial fibrillation
palpitations
heart murmur
mitral valve prolapse

Hematologic/Lymphatics:

anemia
blood clots
swollen glands
excessive bleeding
leukemia
lymphoma
HIV
malignant hyperthermia
lupus
Rheumatoid arthritis

Respiratory:

short of breath
TB
COPD
asthma
emphysema
chronic cough
bronchitis
pneumonia
sleep apnea
sputum production

Gastrointestinal:

abdominal pain
nausea or vomiting
diarrhea or constipation
GERD
heartburn
hiatal hernia
esophageal varices
gastric ulcers
gallbladder disease
rectal bleeding
dark or light stools
hemorrhoids
painful bowel movements
colitis or Crohn's
jaundice
hepatitis or liver disease
ascites
pancreatitis
diverticulosis
aortic aneurysm
groin or abdominal hernias

Musculoskeletal:

Joint pain
leg swelling
pain with rest or walking
muscle pain or cramps
osteoarthritis

Genitourinary:

urinary tract infections
blood in urines
kidney stones
burning with urination
urgency to urinate
prostate problems
testicular problems

Endocrine:

thyroid disease
diabetes
insulin or non-insulin
steroid use
kidney disease or failure
hormone problems
hysterectomy
ovaries removed

Neurologic:

depression or anxiety
strokes
numbness
blackouts
frequent headaches
head injury
paralysis or weakness
fibromyalgia



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