CN MRI 2.0

PATIENT REGISTRATION INFORMATION FORM

Demographic Information

Last name:_____ First name:_____ M.I_____

DOB:_____ SSN:_____

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Cell Phone:_____ Email address:_____

Marital Status:_____ Spouse name:_____

Spouse phone number:_____ Authorized to discuss care? Y/N

Employment

Employer:_____ Occupation:_____

Status: ☐ Full Time ☐ Part Time ☐Self employed ☐ Retired

Health Insurance Information *if Workers Compensation or Auto Accident an additional form is required*

Primary Insurance Company name:_____

Member/ID #:_____ Group# _____

Policy Holder Name if other than insured_____

Relationship:_____ DOB (if other than insured)_____

Secondary Insurance Company name:_____

Member/ID#:_____ Group #_____

Policy Holder Name if other than insured_____

Relationship:_____ DOB (if other than insured)_____

Emergency Contacts

Name:_____ Relationship:_____

Phone number:_____ Authorized to discuss care? Y/N

Can we leave medical information on their voicemail? Y/N

Name:_____ Relationship:_____

Phone number:_____ Authorized to discuss care? Y/N

Can we leave medical information on their voicemail? Y/N

Patient Signature:_____ Date:_____

CNMRI 2.0 MEDICAL HISTORY FORM

Patient Information		
Name	DOB	Gender: M F Other
Address		Phone:
Emergency Contact	Relationship:	Phone:
Primary Care Physician Name		Phone Number
Preferred Pharmacy		Phone Number

Personal history *(check all that apply)*

☐ No known medical conditions
☐ Allergies (please list in next section)
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Blood transfusion
☐ Cancer (Specify: _____)
☐ Congestive heart failure
☐ COPD / Emphysema
☐ Depression
☐ Diabetes (Type 1 / Type 2)
☐ Epilepsy / Seizures
☐ GERD (Acid Reflux)
☐ Glaucoma
☐ Gout
☐ Heart Attack / Heart Disease
☐ High Blood Pressure (Hypertension)
☐ High Cholesterol
☐ HIV/AIDS
☐ Kidney Disease / Kidney Stones
☐ Liver Disease / Hepatitis
☐ Migraines
☐ Osteoporosis
☐ Stroke
☐ Substance Abuse (Alcohol Drugs)
☐ Thyroid Disease (Hypo / Hyper)
☐ Tuberculosis
☐ Ulcers

Other medical issues:

Current Medications: Include prescription, OTC, vitamins, and supplements
***no need to complete if you have a medication list**

Name(s)	Dosage	Frequency	Purpose	Note(s)

Surgeries/Procedures:
☐ Heart surgery ☐ Cholecystectomy ☐ Appendectomy, ☐ C-section ☐ Hysterectomy ☐ Bladder ☐Colonoscopy ☐EGD ☐ Joint ☐Other _____

Allergies

Family history ***(check all that apply and specify relationship)***

☐ No known family history of medical conditions
☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Stroke
☐ Thyroid Disease
☐ Kidney Disease
☐ Mental Health Conditions (Depression, Anxiety, etc.)
☐ Autoimmune Diseases
☐ Other: _____

Social history

Factor	Check one	Most recent date *(if applicable)*
Tobacco Use	Cigarettes Vaping Tobacco	
Alcohol Use	Occasional Moderate Heavy	
Recreational Drugs	No Yes (Specify)	
Caffeine	[ ] Times per week	
Exercise Routine	[ ] Times per week	
Sleep	[ ] Hours a night	

Any Social Detriments to Health? ☐ No ☐ Yes *(describe)* _____

Occupation:	Living Situation: ☐ With roommates ☐ With S/O ☐ With family ☐Other: _____

Review of Systems *(Check any symptoms that you are experiencing currently)*

General	*EENT*	*Cardiovascular*
☐ Fatigue ☐ Fever or chills ☐ Unexplained weight loss/gain	☐ Vision changes (blurry, double vision) ☐ Hearing loss or ringing ☐ Sore throat / Hoarseness	☐ Chest pain or tightness ☐ Palpitations (fast or irregular heartbeat) ☐ Swelling in legs or feet
Respiratory	*Gastrointestinal*	*Genitourinary*
☐ Shortness of breath ☐ Chronic cough ☐ Wheezing	☐ Abdominal pain ☐ Nausea or vomiting ☐ Diarrhea or constipation	☐ Incontinence ☐ Burning ☐Urgency ☐Frequency ☐Blood in urine
Musculoskeletal	*Psychiatric*	*Neurological*
☐ Joint pain or stiffness ☐ Muscle weakness ☐ Back pain	☐ Depression or feeling down ☐ Anxiety or panic attacks ☐ Sleep disturbances (insomnia, nightmares)	☐ Headaches or migraines ☐ Dizziness or lightheadedness ☐ Numbness or tingling

Additional notes:

Patient name:	Date:
Patient signature:	Date:

CNMRI 2.0 No Shows/Late Cancellation Notice to Patients

We have been facing an increasing problem with no shows and last minute cancellations. This is not fair to patients hoping to be seen for sooner appointments. We understand that there are circumstances and/or changes in your schedule that may prevent you from keeping your appointment.

If this situation arises, we ask that you notify us at least one business day in advance and we will gladly reschedule your appointment. You can notify us by a phone call, voicemail or cancelling your appointment electronically through mychart. Please be advised that late cancellation, not showing or rescheduling your appointment in less than one business day from the time of the appointment will result in a $50.00 cancellation fee.

This charge cannot be billed to an insurance carrier. Therefore, it is YOUR financial responsibility.

Appointments will not be rescheduled until the missed appointment charge is paid. Medical care will not be denied for emergency situations or at the treating physician's discretion. Multiple no shows or late cancellations could result in discharge from the practice.

By signing below you acknowledge that you are aware and agree to this policy.

Patient signature_____ Date:_____

For office use only

_____ _____

Staff initials MRN