DR. VIRENDRA AGARWAL M.D.

715 E. CALIFORNIA SUITE D.

GAINESVILLE, TEXAS 76240

PATIENT REGISTRATION FORM

Patient Name (Last, First, MI)_____

Home Phone Number:_____ Cell Phone Number:_____

Email Address:_____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____ Sex: ___ F ___M SS NUMBER:_____

Marital Status:_____ Married _____Single _____ Divorced_____ Widowed_____

Patient's Employer:_____ Employment Status:_____

Emergency Contact:_____ Relationship to Patient:_____

Address:_____ Phone Number:_____

Insurance Information

Primary Insurance_____ Secondary Insurance:_____

Release of Information

I hereby give permission to the person (s) listed below to receive information about the care of above named patient.

Name:_____ **Relationship to Patient**_____

Patient Signature:_____ **Date:**_____

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HEALTH HISTORY

PERSONAL INFORMATION

Race: ____ Asian____ Black or African American____ Native American____ White/Caucasian

Number of Children:_____ Children's Names/Ages:_____

Names/Specialties/Locations of other physicians caring for you, including previous primary care provider:_____

MEDICAL INFORMATION

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Frequency

Any **Allergies** to Medication or Food (list reactions):_____

Preferred **Pharmacy:**_____

Date of Last Complete Physical Exam:_____ Date of Last Blood Work:_____

Date of Last Colonoscopy:_____ Date of Last Tetanus Shot:_____

Date of Last Bone Density:_____ Date of Flu Vaccine:_____

Date of Last PSA:_____ Date of Last Pneumonia Vaccine:_____

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If **YOU** or a **FAMILY MEMBER** has had any of the following, please circle and indicate which family member when applicable:

ADD/ADHD____

ANEMIA____

Allergies/Hay Fever_____

Asthma____

High Cholesterol_____

Heart Attack_____

Sexually Transmitted Disease____

Blood Clots_____

Neurological Disease_____

Type 1 or 2 Diabetes_____

Respiratory Disease____

Fractures_____

Skin Disease____

Gynecological Disease_____

Stomach/Colon Disease_____

High Blood Pressure_____

Stroke_____

Arthritis____

Seizure Disorder_____

Anxiety/Depression_____

Thyroid Disorder_____

Alcoholism_____

Kidney Disease_____

Liver Disease_____

Neurological Disease_____

Osteopenia/Osteoporosis

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SURGERIES

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

SURGERY	DATE

Social Information

Tobacco Use: Do you smoke?_____ If so, how many cigarettes/cigars per day:_____ No. of years smoking:_____ Do you chew tobacco_____ Have you thought about quitting?___ Have you quit before?_____ How long?_____

Alcohol Use: Do you drink alcohol?_____ If so, what type?_____ When?_____

Drug Use: Any history of illegal drug use?_____ If so, what type/s?_____ When?_____

Do you **Exercise**?_____ What activities do you do, and how often in 1 week?_____

_____

Are you on any special diet?_____ If so what?_____

Do you consume **Caffeinated** products?_____ If so, what and how much per day?_____

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Have you recently noticed an increase in sadness or gloominess?_____

Have you lost interest in enjoyable activities?_____

Do you have a living will? _____ if yes please provide us with a copy.

HIPPA PRIVACY ACT INFORMATION FORM

Please check the appropriate boxes below:

Medical information may be released only to me the patient

☐ Yes ☐ No

Medical Information may be release to my Spouse

☐ Yes ☐ No

Spouse Full Name _____

Medical Information may be released to any other person listed below:

_____ _____

LAST NAME, FIRST NAME, MI DATE OF BIRTH

_____ _____

LAST NAME, FIRST NAME, MI DATE OF BIRTH

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ACKNOWLEDGMENT OF RECEIPT/REVIEW OF NOTICE OF PRIVACY PRACTICES

I, _____, have been given a copy of the Notice of Privacy Practices to review. I am awake that Dr. Agarwal's office reserves the rights to modify the privacy practice outlines in the notice. I was given the choice to receive a copy of these practices. I ☐ declined a copy

☐ Received a copy of the Notice of Privacy Practices.

_____

Patient's Name (PRINT)

_____

Patient Signature

_____

Today's Date