Block Island Medical Center
R E G I S T R A T I O N
Please Print

DATE:_____

PATIENT INFORMATION

Home Phone: _____ - _____ - _____ Island/Cell #: _____ - _____ - _____ Work #: _____ - _____ - _____

Name: _____ **SSN**: _____ - _____ - _____
Last Name First Name MI

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Race: ☐ White ☐ African American ☐ Native American/Alaskan ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Other

DOB: ____/____/_____ **Age**: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced **Sex**: ☐ M ☐ F
Month Day Year

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown **Primary Language**: _____

In Case of Emergency: _____ Relationship: _____ Phone: _____ - _____ - _____

INSURANCE

Insurance Company: _____ Subscriber #:_____

Subscriber's Name: _____ Home Phone: _____
Last First MI

Relationship to Patient: _____ DOB: _____/____/_____ SSN: _____ - _____ - _____
Month Day Year

Address (If Different From Patient): _____ State: _____ Zip Code: _____

Secondary Insurance: _____ Subscriber #:_____

Subscriber's Name: _____ Home Phone: _____
Last First MI

Relationship to Patient: _____ DOB: _____/____/_____ SSN: _____ - _____ - _____
Month Day Year

Address (If Different From Patient): _____ State: _____ Zip Code: _____

PRIMARY CARE PHYSICIAN INFORMATION

Name of Primary Care Provider: _____ Telephone #: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip Code: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Primary Insurance Company

and assign directly to Block Island Health Services Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I also acknowledge that I have received the Notice of Privacy Practices dated April 14, 2003, on the date below.

_____ _____
Signature of Patient or Authorized Representative Date

See Other Side

HEALTH HISTORY

Name: _____ Date of Last Physical Exam: _____/_____/_____

Current Reason for Visit? _____

_____

CONDITIONS: Check (√) conditions you have or have had in the past

☐ AIDS	☐ Breast Lump	☐ Glaucoma	☐ Kidney Disease	☐ Sexually Transmitted Disease
☐ Alcoholism	☐ Bronchitis	☐ Gout	☐ Liver Disease	☐ Stroke
☐ Anemia	☐ Cancer	☐ Heart Disease	☐ Migraine Headaches	☐ Suicide Attempt
☐ Angina	☐ Cataracts	☐ Heart Murmur	☐ Miscarriage	☐ Thyroid Problems
☐ Anorexia	☐ Chemical Dependency	☐ Hepatitis	☐ Mononucleosis	☐ Tonsillitis
☐ Anxiety	☐ Depression	☐ Hernia	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Appendicitis	☐ Diabetes	☐ Herpes	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Eating Disorder	☐ High Blood Pressure	☐ Pneumonia	☐ Urinary Tract Infection
☐ Asthma	☐ Emphysema	☐ High Cholesterol	☐ Prostate Problem	☐ Vaginal Infection
☐ Bleeding Disorder	☐ Epilepsy	☐ Irregular Heart Beat	☐ Rheumatic Fever	☐ Other _____

MEDICATIONS: List medications you are currently taking	**ALLERGIES:** To medications/substances
Last Tetanus:	

Pharmacy Name: _____ **Phone:_____ - _____ - _____**

FAMILY HISTORY: Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if your blood relatives had any of the following **Disease**	**Relationship to You**
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease, Stroke	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

HOSPITALIZATIONS / SURGERIES | PREGNANCY HISTORY

Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex of Birth	Complications, if any

HEALTH HABITS: Check (√) which substances you use and describe how much you use

☐ Caffeine _____ ☐ Tobacco _____ ☐ Drugs _____ ☐ Alcohol _____ ☐ Other_____