ProHEALTH℠ Care

Welcome to ProHEALTH Care Associates, LLP.

PATIENT REGISTRATION FORM

In order to serve you, we need the following information. Please print.

Today's Date:

Thank you for selecting ProHEALTH Care Associates.

PATIENT INFORMATION

Patient's Last Name: First: Middle: Gender: Age: Birth Date:

Marital Status: S M D W SEP

Preferred Language:

Student: ☐ Part Time ☐ Full Time

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Street Address: Apt # City/Town: State: Zip Code: Home Phone No.:

Mobile Phone No.: Email Address: Work No.:

Name of Employer: Address: City/Town: State: Zip Code:

SPOUSE'S INFORMATION

Last Name: First: Middle: Gender: Age: Birth Date:

Mobile Phone No.: Work No.:

Employer: Street Address: City/Town: State: Zip Code:

PARENT INFORMATION

Complete the section below with your parent's information if you are a full time student covered under their health insurance.

Insured's Last Name: Insured's First: Middle: Gender: Age: Birth Date:

Mobile Phone No.: Work No.:

Employer: Street Address: City/Town: State: Zip Code:

EMERGENCY CONTACT

Name: Relationship to Patient:

Primary Telephone No.: Secondary Telephone No.:

PRIMARY CARE PHYSICIAN

Primary Care Physician Name:

Street Address:

City, State, Zip: Telephone No.:

REFERRING PHYSICIAN

Referring Physician (if not same as PCP):

Street Address:

City, State, Zip: Telephone No.:

Please provide the name/s and telephone numbers of any other doctors treating you at this time.

PHARMACY INFORMATION

Name of Pharmacy: Address: Telephone No.: Fax No.:

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE

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

Insurance Name: Claims Address: Telephone No.: Group No.:

ID No.:

Insured's Name (if not self, spouse or parent listed above): Birth Date:

SECONDARY INSURANCE

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

Insurance Name: Claims Address: Telephone No.: Group No.:

ID No.:

Insured's Name (if not self, spouse or parent listed above): Birth Date:

WORKER'S COMPENSATION INFORMATION

Is the reason for this visit due to a work related accident? ☐ Yes ☐ No **If yes, you must complete this section.**

Date of Injury/Onset of Illness: Employers Insurance Carrier Name & Address:

WCB Case No.: Carrier Case No.:

Are you currently working? ☐ Yes ☐ No Last Day Worked:

Briefly describe how and where patient's injury occurred:

NO FAULT INFORMATION

Is the reason for this visit due to a motor vehicle accident? ☐ Yes ☐ No **If yes, you must complete this section.**

Date of Accident: Insurance Carrier Name: Address:

Policyholder's Name: Policy No.: Claim No.:

Relationship to Insured: ☐ Self ☐ Spouse ☐ Other: Claims Adjuster: Telephone No.:

Are you currently working? ☐ Yes ☐ No Last Day Worked:

Briefly describe how and where patient's injury occurred:

ATTORNEY INFORMATION

Law Firm Name: Address: Name of Attorney Handling Case: Telephone No.:

Fax No.:

PATIENT SIGNATURE: ______________________________ **DATE:** ______/______/______

ProHEALTH Care
Urology
1 Dakota Drive Suite 110
Lake Success, NY 11042
Phone: 516-622-6110 Fax: 516-608-2805

NEW PATIENT PACKET

Date of Appointment: ____________________

Patient name:
Date of Birth:

Ref Physician: ____________________

PCP: ____________________

Chief Complaint What is the reason for your visit today? (Describe your problem)

____

____

____

Past Medical History

List all past and present medical problems

____

____

____

____

____

Past Surgical History

List any past surgeries and when they occurred

____

____

____

____

____

Social History

Tobacco Use:
[ ] Never
[ ] Current
Year started: ________
Cigarettes [ ] Yes [ ] No Amt: ______ (packs/day)
Cigars [ ] Yes [ ] No Amt: ______ (# / week)
Smokeless [ ] Yes [ ] No Amt: ______ (per day)
[ ] Quit
Year quit: ________
Drug Use:
[ ] Yes [ ] No
Substance: ____________________
Do you Drink?
[ ] Yes [ ] No
Type: ____________________

Number of drink(s) per day: ________

Family History

List all the medical problems in your immediate family
[ ] Family history of Prostate Cancer
[ ] Family history of Kidney Cancer
[ ] Family history of Kidney Stones

____

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____

____

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Note This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Name: **DOB:**

Review of Systems

Do you now or have you had any problems related to the following systems? Please check box
You may explain any positive answers in the space provided

Constitutional Symptoms		
Fever	[ ] Yes	[ ] No
Chills	[ ] Yes	[ ] No
Headache	[ ] Yes	[ ] No
Eyes		
Blurred vision	[ ] Yes	[ ] No
Double vision	[ ] Yes	[ ] No
Neurologic		
Tremors	[ ] Yes	[ ] No
Dizzy spells	[ ] Yes	[ ] No
Numbness	[ ] Yes	[ ] No
Tingling	[ ] Yes	[ ] No
Endocrine		
Excessive thirst	[ ] Yes	[ ] No
Too hot	[ ] Yes	[ ] No
Too cold	[ ] Yes	[ ] No
Tired	[ ] Yes	[ ] No
Sluggish	[ ] Yes	[ ] No
Gastrointestinal		
Abdominal pain	[ ] Yes	[ ] No
Constipation	[ ] Yes	[ ] No
Nausea	[ ] Yes	[ ] No
Vomiting	[ ] Yes	[ ] No
Indigestion	[ ] Yes	[ ] No
Heartburn	[ ] Yes	[ ] No
Cardiovascular		
Chest pain	[ ] Yes	[ ] No
High blood pressure	[ ] Yes	[ ] No
Skin		
Skin rash	[ ] Yes	[ ] No
Boils	[ ] Yes	[ ] No
Persistent itch	[ ] Yes	[ ] No
Genitourinary		
Urine infections(bladder/kidney)	[ ] Yes	[ ] No
Painful Urination	[ ] Yes	[ ] No
Blood in urine that you can see	[ ] Yes	[ ] No
Blood in urine on a urine test	[ ] Yes	[ ] No
Discharge from urine canal	[ ] Yes	[ ] No
History of Kidney stones	[ ] Yes	[ ] No
Stones in urine	[ ] Yes	[ ] No
Leak urine	[ ] Yes	[ ] No
Leak urine with cough/ Strain/laughing	[ ] Yes	[ ] No
Strong urge to urinate	[ ] Yes	[ ] No
Strong urge to urinate causing leak of urine	[ ] Yes	[ ] No
Bladder pressure	[ ] Yes	[ ] No
Frequent urination	[ ] Yes	[ ] No
Strain or push to urinate	[ ] Yes	[ ] No
Wait a long time to urinate	[ ] Yes	[ ] No
Slow urine stream	[ ] Yes	[ ] No
Interrupted urine stream	[ ] Yes	[ ] No
Dribbling of urine	[ ] Yes	[ ] No
Urine retention	[ ] Yes	[ ] No
Bladder fullness after urinating	[ ] Yes	[ ] No
Wake up at night to urinate	[ ] Yes	[ ] No
Musculoskeletal		
Joint pain	[ ] Yes	[ ] No
Neck pain	[ ] Yes	[ ] No
Back pain	[ ] Yes	[ ] No
Ear/Nose/Throat/Mouth		
Ear infection	[ ] Yes	[ ] No
Sore throat	[ ] Yes	[ ] No
Sinus problems	[ ] Yes	[ ] No
Respiratory		
Wheezing	[ ] Yes	[ ] No
Frequent cough	[ ] Yes	[ ] No
Shortness of breath	[ ] Yes	[ ] No
Hematological/Lymphatic		
Swollen glands	[ ] Yes	[ ] No
Blood clotting problems	[ ] Yes	[ ] No
Excessive bleeding	[ ] Yes	[ ] No
Sexual History		
Painful intercourse	[ ] Yes	[ ] No
Loss of interest	[ ] Yes	[ ] No
Interested in treatment/ evaluation of sexual problem	[ ] Yes	[ ] No
Genital Infections		
Genital bacterial infection	[ ] Yes	[ ] No
Genital yeast infection	[ ] Yes	[ ] No
Sexual Transmitted Disease (STD)	[ ] Yes	[ ] No

Name: **DOB:**

MEDICATION LIST

ALLERGIES: No allergies recorded.

MEDICATIONS LISTED IN EMR:
DEXAMETHASONE 0.5 MG ORAL TABLET (DEXAMETHASONE) One tablet by mouth per day

MEDICATIONS (NAME AND DOSE)	ORDERING PHYSICIAN