

Patient Registration Form

Patient Information

Patient's last name (please print)	First name	Middle name	Nickname
Birthdate	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
Home address		Home phone #	Today's date
		Cell phone #	e-mail address

Responsible Party Information

Name of person responsible for payment of fees		DOB	
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Married		
Last name	First name	<input type="checkbox"/> Divorced	
		<input type="checkbox"/> Separated	
Relationship to patient:	<input type="checkbox"/> Parent	Home phone #	Cell phone #
	<input type="checkbox"/> Guardian		
	Other (list)		
Address	Home fax #	e-mail address	
	Work phone #	Best number to call	
	Social security #	CA driver's license #	
Employer	Occupation		

Other Parent/Guardian Information

Other parent or guardian		DOB	
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Married		
Last name	First name	<input type="checkbox"/> Divorced	
		<input type="checkbox"/> Separated	
Relationship to patient	<input type="checkbox"/> Self	Home phone #	Cell phone #
	<input type="checkbox"/> Parent		
	<input type="checkbox"/> Other (list)		
Address	Home fax #	e-Mail	
	Work phone #	Best number to call	
	Employer	Occupation	

In Case of Emergency

Name of local friend or relative (not living at same address)	Relationship to patient	Home phone #	Other phone #
Street Address	City	State	Zip

Signature

I verify the above information to be true and accurate to the best of my knowledge. I accept financial responsibility for charges resulting from today's visit.

Signature of Responsible Party

Print name

Date

Are there any foods you cannot eat due to allergy, intolerance, or for another reason?

Food	Describe reaction

Do you wear glasses contact lenses neither

About how long ago did you last see your dentist?

About how tall are you?

Health Habits

Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Nicotine	<input type="checkbox"/> None	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Other (please name)	
	# of cigarettes or packs per day?			
Alcohol	<input type="checkbox"/> None	# of drinks per day	or, # of drinks per week	
	Past use			
Other drugs	Recent use	<input type="checkbox"/> None	Other:	
	Past use	<input type="checkbox"/> None	Other:	

Menstrual History

Age at onset of menstruation:		Date of last menstruation:		
<input type="checkbox"/> Periods regular, about every ____ days	<input type="checkbox"/> Periods irregular, but usually 1 period every couple of months	<input type="checkbox"/> Periods irregular		
Do you have cramps with your periods? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you get adequate relief with over-the-counter medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have heavy periods, irregularity, spotting, or discharge? (Circle which of these you have.)				
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last pap exam, if you've had one		Number of pregnancies, if any		

Family Health History

Age		Significant health problems		Age		Significant health problems	
Father				Grandmother <i>Maternal</i>			
Mother							
Sibling Name	Age	Significant health problems					
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandfather <i>Maternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandmother <i>Paternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F						
				Grandfather <i>Paternal</i>			

Other Problems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

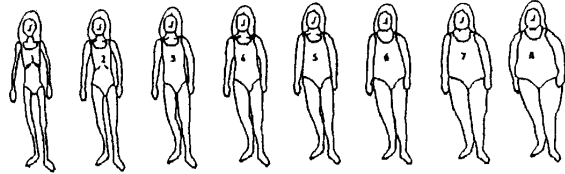
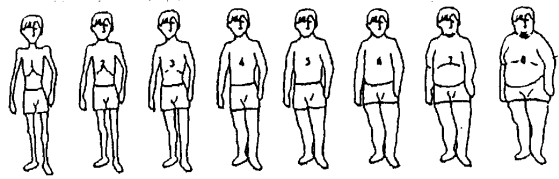
<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Do you have any other concerns you would like to discuss with Dr. Johnson?

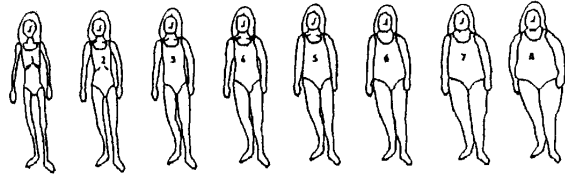
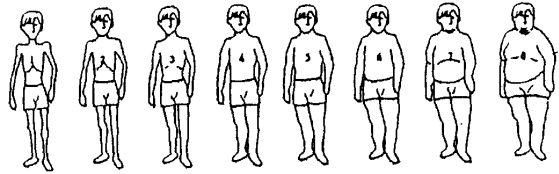
Name: _____

Date: _____

Please circle the drawing that looks most like you today.



Please circle the drawing that shows how you would like to look.



Adolescent and Young Adult Medicine
355 Placentia Avenue, Suite 305
Newport Beach, CA 92663-3311
t 949.856.2701 f 949.625.7516 www.drjohnsoninfo.medem.com

Authorization to Use, Disclose, and/or Receive Protected Health Information

As required by federal HIPAA Privacy Regulations, Dr. Johnson may not use or disclose your protected health information (PHI) without your authorization, except as provided in the Notice of Privacy Practices.

Patient name _____ Date of birth _____ Today's date _____
Address _____ Patient's SSN _____

I authorize Jennifer Johnson, M.D. to use, disclose to, and/or receive health and/or educational information from:

Name and contact information of parent, doctor, health care provider, hospital, and/or other: _____

Health/education information authorized to be disclosed/received may include any or all of the following:

- Medical records
- Discharge summaries
- Therapy/counseling records or summaries
- Telephone communications
- Psychological evaluations
- Psychiatric evaluations
- School transcripts and records

I furthermore authorize information to be faxed. Patient initials:

Specific purpose of disclosure:

- All healthcare information
- Healthcare information relating to the following treatment, condition, or dates: _____
- Other (describe): _____

Effective dates for this authorization:

from _____ through _____
Start date (usually today's date) End date

This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond Dr. Johnson's control. Dr. Johnson will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I understand I have the right to:

1. revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. knowledge of any compensation involved due to any marketing activity as allowed by this authorization and as a result of this authorization.
3. inspect a copy of Patient Health Information being used or disclosed under federal law.
4. refuse to sign this authorization.
5. receive a copy of this authorization.
6. restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my/my child's treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected client health information.

Patient Signature Date Jennifer Johnson, M.D. Date