WEISER MEMORIAL
HOSPITAL & CLINICS

PATIENT REGISTRATION

Today's Date _____

Patient Legal Last Name	First Name Middle Initial		Preferred Name
Address	Gender ☐ Male ☐ Female ☐ Other		Date of Birth / /
City	State	Zip	Social Security Number
Email Address	Preferred Physician/Provider		Are you wanting to make FMC your Medical Home? ☐ Yes ☐ No ☐ Not Sure
Primary Phone ☐ Home ☐ Cell ☐ Work	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Partnered		
Would you like your records transfered? ☐ Yes ☐ No	Preferred Pharmacy Name & Location		
Guarantor Name (if other than patient)	Patient Relationship to Guarantor ☐ Spouse/Partner ☐ Child ☐ Other		Guarantor Date of Birth / /
Address (if different than patient)			Phone Number ☐ Home ☐ Cell ☐ Work

Insurance Information

Primary Insurance Company		Secondary Insurance Company	
Address		Address	
ID Number	Group Number	ID Number	Group Number
Group Name of Employer		Group Name of Employer	
Subscriber Name (If other than patient)		Subscriber Name (if other than patient)	
Subscriber Relation to Patient	Date of Birth / /	Subscriber Relation to Patient	Date of Birth / /

Emergency Contact

Name	Phone Number(s)	Relationship

How did you hear about Family Medical Center?

☐ Newspaper ☐ Social Media ☐ Community Event ☐ Hospital ☐ Referral ☐ Other

Race? *(Federal Statistics and Administration reporting for medical research purposes)*

☐ I decline to answer ☐ American Indian or Alaska Native ☐ Asian ☐ Two or more races
☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ White

Ethnicity? *(Federal Statistics and Administration reporting for medical research purposes)*

☐ I decline to Answer ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Preferred Language _____ ☐ Interpreter Needed

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MEDICAL HISTORY

Name _____ Date of Birth _____ Gender: ☐ Male ☐ Female ☐ Other

FAMILY HISTORY *(Please check all that may apply)*

	Father	Mother	Brother	Sister
Cancer	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Stroke	☐	☐	☐	☐

	Father	Mother	Brother	Sister
Seizure Disorder	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐

Other _____

Other Family History _____

PERSONAL HISTORY

ILLNESSES *Please check all that you have been treated for.*

- Alcohol Trouble ☐
- Anxiety ☐
- Asthma ☐
- Back Trouble ☐
- Bleeding Disorder ☐
- Cancer ☐
- Chicken Pox ☐
- Depression ☐
- Diabetes ☐
- Epilepsy ☐
- Fainting Spells ☐
- German Measles ☐
- Glaucoma ☐
- Heart Disease ☐
- Heart Murmur ☐
- Hepatitis ☐
- High Blood Pressure ☐
- High Cholesterol ☐
- Kidney Trouble ☐
- Lung Respiratory Disease ☐
- Lung Trouble ☐
- Measles ☐
- Memory Loss ☐
- Migraine ☐
- Mononucleosis ☐
- Mumps ☐
- Nervous Breakdown ☐
- Peptic Ulcer ☐
- Polio ☐
- Pheumatic Fever ☐
- Scarlet Fever ☐
- Sexual Diseases ☐
- Stomach Ulcer ☐
- Stroke ☐
- Thyroid Trouble ☐
- Tuberculosis (T.B.) ☐
- Urinary Tract Infection ☐
- Whooping Cough ☐
- Other Illnesses ☐

If yes, please describe

_____

_____

SURGERIES

Accidents/Fractures ☐

If yes, please describe

_____

_____

_____

- Appendectomy ☐
- Back ☐
- Breast ☐
- Cataract ☐
- Colon or Intestine ☐
- Ear Tube Replacement ☐
- Gallbladder ☐
- Hernia ☐
- Heart ☐
- Hysterectomy ☐
- Prostate ☐
- Tonsillectomy ☐
- Other Surgeries ☐

If yes, please describe ☐

_____

_____

HABITS

	How Much?
Tobacco ☐	_____
Alcohol ☐	_____
Drugs ☐	_____
Caffeine ☐	_____
Exercise ☐	_____

SOCIAL HISTORY ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partnered

Date of Previous Screening Tests: *(If applicable)*

Pap Smear _____

Mammogram _____

Bone Density _____

Colonoscopy _____

Immunization Dates: *(If applicable)*

Pneumococcal _____

Flu _____ Tetanus _____

Ophthalmologist Visit: *(If applicable)*

Date _____

Name _____

ALLERGIES *(If applicable)*

CURRENT MEDICATIONS *(List by name, including over the counter)*

_____ _____ _____

_____ _____ _____

_____ _____ _____