Michigan Avenue Immediate Care
James A. Runke, M.D., Medical Director

Patient Registration Form

Office Use Only	
Hx	
Demos	
ROS	
Portal	
Pmt	
Records	

Date of Appointment: _____

Patient Information

Last Name (as it appears on insurance card or ID)	First Name	Middle Name	Preferred Name (Ex. "Mike" or "Jenn"

Sex	Social Security Number	Marital Status	Date of Birth

Patient's Billing Address	Apt/Unit Number	City	State	Zip

Home Phone	Mobile Phone	Email Address

Preferred Pharmacy Name	Pharmacy Phone	Pharmacy Address

Race

□ African American / Black □ American Indian / Alaska □ Asian
□ Caucasian / White □ Native Hawaiian / Pacific Islander □ Other Race □ Decline

Ethnic group

□ Hispanic / Latino □ Non-Hispanic / Latino □ Decline

Patient Employer/School Information

Employer/School	Occupation	Employment Status
		□Full-time employed □ Part-time employed □ Not employed □ Self-employed □ Retired □Full-time student □ Part-time student □ On active military duty □ Decline/other

Continuity of Care

If you would like today's Visit Summary sent to your Primary Care Physician, please complete this section.
*** Please note:** Visit Summary will not be sent if **fax number** is not provided.

Primary Care Physician's Name	Primary Care Physician's **Fax Number**:

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

If anyone else should be involved in your Medical care, please indicate here:

Name		Name	
Phone Number	**Relation to Patient**	**Phone Number**	**Relation to Patient**

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan Number	Group Number

Insurance Claim Address (As listed on the back of the card)	Insurance Phone Number

Secondary Health Insurance

Insurance Company	Plan Number	Group Number

Insurance Claim Address (As listed on the back of the card)	Insurance Phone Number

Policyholder Information

Name of Policy Holder	Phone	Relation to Patient

Social Security Number	Date of Birth

Address	City	State	Zip

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Is the reason for your visit related to an Injury or accident?

☐ No ☐ Yes STOP ***Please notify the Front Desk Staff if you have been in an auto accident or have a Work-Related injury***

If Yes, place of injury/accident::	Please explain injury/accident:

What brings you to the office today?

_____

Do you have any chronic medical conditions?

_____

Current Medications

What medications are you currently taking? ☐ None

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following? ☐ None

☐ Adhesive Tape ☐ Penicillin ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke ☐ None of the above

Hospitalizations & Surgeries

Reason	Date

Women Only:

# of Pregnancies	# of Miscarriages	# of Abortions	# of Living

Last Pap Smear	Last Mammogram	Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details:

Lifestyle Factors

Are you sexually active?
☐ Yes ☐ No # of partners in past year _____

Have you ever smoked?
☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?
☐ Yes ☐ No # packs/day _____

Do you drink alcohol?
☐ Yes ☐ No # times/week _____

Do you use recreational drugs?
☐ Yes ☐ No Types? _____ # times/week _____

How often do you exercise?
times/week __

Review of Systems

CAGE: Do you drink Alcohol?

- [ ] No
- [ ] Yes (please answer if any apply):
  - [ ] I have felt I need to cut down on my drinking
  - [ ] People have annoyed or criticized me about my drinking
  - [ ] I have felt guilty about my drinking
  - [ ] I have felt like I needed a drink first thing in the morning

PHQ2: In the past 2 weeks:

- [ ] I have had little interest or pleasure in doing things
- [ ] I have felt down, depressed, or hopeless

General

- [ ] Chills
- [ ] Dizziness
- [ ] Fainting
- [ ] Fever
- [ ] Hair Loss
- [ ] Hair Growth – Excessive
- [ ] Night Sweats
- [ ] Sleeping Problems
- [ ] Thirst - Excessive
- [ ] Weight Gain
- [ ] Weight Loss

Mental Health

- [ ] Anxiety
- [ ] Depression
- [ ] Loss of Interest
- [ ] Feeling Hopeless
- [ ] Hearing Voices
- [ ] Marital Problems
- [ ] Panic Attacks
- [ ] Trouble Concentrating
- [ ] Suicide –Thoughts / Attempts

Skin

- [ ] Acne
- [ ] Bruise Easily
- [ ] Change in Moles
- [ ] Chills
- [ ] Dry / Sensitive Skin
- [ ] Eczema
- [ ] Hives
- [ ] Itching
- [ ] Rash
- [ ] Scars
- [ ] Sores That Won't Heal

Gastrointestinal

- [ ] Appetite Gain
- [ ] Appetite Loss
- [ ] Bloating
- [ ] Bowel Changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Intestinal Disorder
- [ ] Lactose Intolerance
- [ ] Nausea
- [ ] Rectal Bleeding
- [ ] Stomach Pain
- [ ] Vomiting
- [ ] Vomiting Blood

Genitourinary

- [ ] Blood in Urine
- [ ] Lack of Bladder Control
- [ ] Frequent Urination
- [ ] Painful Urination

Neurological

- [ ] Coordination Problems
- [ ] Convulsions
- [ ] Difficulty Walking
- [ ] Learning Disabilities
- [ ] Light-headedness
- [ ] Memory Loss
- [ ] Numbness / Tingling
- [ ] Paralysis
- [ ] Seizures
- [ ] Speech Problems
- [ ] Tremors

ENT

- [ ] Bleeding Gums
- [ ] Blurred Vision
- [ ] Crossed Eyes
- [ ] Difficulty swallowing
- [ ] Double Vision
- [ ] Earaches
- [ ] Ear Discharge
- [ ] Hay Fever
- [ ] Hoarseness
- [ ] Hearing Loss
- [ ] Nose-Bleeds
- [ ] Persistent Cough
- [ ] Persistent Runny Nose
- [ ] Recurring Sore Throat
- [ ] Ringing in Ears
- [ ] Sinus Problems
- [ ] Vision Halos

Respiratory

- [ ] Coughing
- [ ] Coughing Up Blood
- [ ] Shortness of Breath
- [ ] Wheezing

Cardiovascular

- [ ] Chest Pains
- [ ] Irregular Heart Beat
- [ ] Circulation Problems
- [ ] Heart Palpitations
- [ ] Rapid Heartbeat
- [ ] Swelling of Ankles
- [ ] Varicose Veins

Musculoskeletal

- [ ] Back Pain
- [ ] Carpal Tunnel Syndrome
- [ ] Joint Pain
- [ ] Joint Swelling
- [ ] Neck Pain
- [ ] Shoulder Pain

Men Only

- [ ] Erection difficulties
- [ ] Lump in Testicles
- [ ] Penile Discharge
- [ ] Sore on Penis

Women Only

- [ ] Abnormal Pap Smear
- [ ] Bleeding between Periods
- [ ] Breast Lump
- [ ] Extreme Menstrual Pain
- [ ] Hot flashes
- [ ] Nipple Discharge
- [ ] Painful Intercourse
- [ ] Vaginal Discharge

Acknowledgement of Receipt Administrative Policies

1. I acknowledge that I have received and understand the Michigan Avenue Immediate Care Follow-up Instructions, including the xray follow-up instructions.

   In summary,

   I will follow up as needed with the referral physician(s) provided for me at the time of my visit and/or at Michigan Avenue Immediate Care.

   I will carefully review the precautions and warnings concerning my prescribed medications before initiating treatment.

   I will follow up as needed with a health care provider if I have any questions, uncertainty or need additional assistance.

   I have received a copy of the physician referral list.

2. I acknowledge receipt of the Michigan Avenue Immediate Care Notice of Privacy Practices (NPP).

3. I have read and understand the Michigan Avenue Immediate Care and Michigan Avenue Primary Care Fee and Payment Policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time without notification.

   I authorize Michigan Avenue Immediate Care to bill my insurance company for all services provided on this and all future visits. I authorize payment to the provider and understand that the processing of medical insurance is done as a courtesy and that I am ultimately responsible for payment of medical bills incurred.

   I authorize the release of any medical information necessary to process this claim for health care payment only.

Signature of Patient or Guardian: _____ Date: _____

Signature of MAIC staff: _____ Date: _____