



South Bay Sports And Preventive Medicine Associates



NEW PATIENT REGISTRATION FORM

Location: Winchester Japan Town

Today's date:		Primary Doctor:			
PATIENT INFORMATION					
Patient's Last Name:		First:	Middle Initial:	What is your gender identity? <input type="checkbox"/> M <input type="checkbox"/> F What sex were you assigned at birth? <input type="checkbox"/> M <input type="checkbox"/> F	What pronoun do you prefer?
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:
Mailing Address:		Social Security No.:		Home Phone No.: ()	
City:	State:	ZIP Code:		Cell Phone No.: ()	
Occupation:		Employer:		Employer's Phone No.: ()	
Referred to us by (PLEASE CHECK ONE) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family					
<input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Website <input type="checkbox"/> Other					
INSURANCE INFORMATION					
(If you brought your insurance card please give your Insurance card/card's to the receptionist and skip this section.)					
Person responsible for bill:		Birth date: / /	Address (if different):		Phone No.: ()
Occupation (if different):	Employer:	Employer address:			Employer Phone No.: ()
Please indicate primary insurance:					
Group #:					
Policy#:					
Co. Payment:					
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
IN CASE OF EMERGENCY					
Name of local friend or relative:		Relationship to patient:		Phone No.: ()	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize South Bay Sports & Preventive Associate, Inc. or insurance company to release any information required to process my claims.					
Patient/Guardian Signature _____				Date _____	

South Bay Sports and Preventive Medicine Associates, Inc. (SBSPMA) HIPAA

Patient acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices of (SBSPMA)

I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at my next appointment.

Patient Signature (if over 18) _____ Date: _____

Parent/Guardian Signature (if under 18) _____ Relationship to patient: _____



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SBSPMA

NEW PATIENT MEDICAL HISTORY FORM

Location: Winchester Japan Town

PATIENT INFORMATION

Name:		Date of Birth:
What name do you like to be called?	Would you like to sign up with our portal (Elation Passport)? <input type="checkbox"/> Yes <input type="checkbox"/> No	EMAIL: CELL NUMBER:

MEDICAL HISTORY

Have you ever been treated for any of the following medical conditions?

<input type="checkbox"/> No changes from previous	<input type="checkbox"/> Cancer	Please list any additional medical conditions: _____ Have you ever been hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list, or mark as unchanged) _____ <input type="checkbox"/> Unchanged from Previous
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression/anxiety	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart problems	
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High cholesterol	
<input type="checkbox"/> Irritable bowel	<input type="checkbox"/> Lung problems	
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Thyroid problems	

MEDICATIONS AND ALLERGIES

Do you take any medications regularly? Yes No If yes, please list:

Do you have any allergies to medications? Yes No If yes, please list:

Do you take any supplements (calcium/vitamin D/fish oil/multivitamin)? Yes No If yes, Please list:

FAMILY HISTORY

Please list any known medical problems for the relatives listed below (For example: diabetes, breast/colon/ovarian/ prostate cancer, heart attacks, high blood pressure, alcohol abuse, depression, skin cancer, osteoporosis)

<input type="checkbox"/> No changes from previous	Mother: _____
Father: _____	Brother/Sister: _____
Children: _____	Other: _____

Is there anything else we should know? _____