Trinity Medical Services

Patient Registration

Patient Information			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Home Phone	Cell Phone	E-mail Address	
SSN	Gender ☐ M ☐ F Gender Identity:	Height	Weight
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	Preferred Contact ☐ Mail ☐ Cell Phone ☐ Work Phone ☐ Patient Portal (MyChart)	Ethnicity ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined	Race ☐ American Indian or Alaskan Native ☐ Black or African American ☐ White ☐ Other
Preferred Language	Primary Care Provider	Referring Provider	

Responsible Party (Guarantor)		Same as patient ☐	
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Home Phone	Cell Phone	E-mail Address	
SSN	Relationship to Patient	Preferred Language	

Emergency Contact			
First Name	Last Name		
Address	City	State	Zip
Home Phone	Cell Phone	Preferred Language	

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

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Advanced Directives
☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ Health Care Proxy

Medications – List all medications you take, prescription and non-prescription and the dosage		
☐ I don't not take any medications		
Medication	Strength	Dose (how often)

Medications and Food Allergies – List all known allergies (drugs, food, animals, etc.)	
☐ No known allergies	

Insurance Information			
Primary Health Insurance		Policy #	Group #
Policy Holders Name	Date of Birth	Employer	
Secondary Health Insurance		Policy #	Group #
Policy Holders Name	Date of Birth	Employer	
Is there another insurance primary to Medicare ☐ No ☐ Yes If yes, reason:			
Do you have active Medicaid insurance: ☐ No ☐ Yes			
Is today's visit relates to an automobile or work injury: ☐ No ☐ Yes			

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Medical History - Check if you have ever experienced the following conditions and year of onset.

Condition	Year	Condition	Year
Anemia		Hyperlipidemia	
Angina		Hypertension	
Anxiety		Irritable Bowel Disease	
Arthritis		Kidney Disease	
Asthma		Liver Disease	
Atrial Fibrillation		Migraine Headaches	
Bleeding Disorder		Multiple Sclerosis	
Blood Clots		Myocardial Infarction	
Cancer – Type		Osteoarthritis	
Cardiovascular Disease		Osteoporosis	
Chemical Dependency		Peptic Ulcer Disease	
Coronary Artery Disease		Pneumonia	
COPD (Emphysema)		Renal Disease	
Crohn's Disease		Respiratory Disease	
Depression		Seizure Disorder	
Diabetes		Sleep Apnea	
Gallbladder Disease		Thyroid Disease	
GERD (Reflux)		Other:	
Gout		Other:	
Hepatitis A. B or C (circle one)		Other:	

Current Symptoms – health problems you are currently experiencing

☐ Chills ☐ Fainting ☐ Impaired growth ☐ Change in height ☐ Change in weight ☐ Shaking ☐ Other: _____	☐ Blood clots ☐ Edema ☐ Cold extremities ☐ Fainting ☐ Dizziness ☐ Chest pain ☐ Other: _____	☐ Abdominal pain ☐ Change in appetite ☐ Constipation ☐ Diarrhea ☐ Excessive vomiting ☐ Other: _____
☐ Bruising ☐ Lesions ☐ Ulcers ☐ Rash ☐ Brittle Nails ☐ Thickened Nails ☐ Other: _____	☐ Confusion ☐ Depression ☐ Vertigo ☐ Numbness ☐ Tingling ☐ Weakness ☐ Other: _____	☐ Difficulty Ambulating ☐ Instability ☐ Muscle Cramping ☐ Muscle Stiffness ☐ Leg Swelling ☐ Falls ☐ Other: _____
Assistive Devise ☐ No ☐ Yes If yes, please list:		

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Surgical History – Check if you have received the following procedure and the year performed			
Surgical Procedure	Year	Surgical Procedure	Year
Angioplasty		**Male Only**	
Angioplasty w/Stent		Prostate Biopsy	
Appendectomy		TURP	
Arthroscopy Knee		**Female Only**	
Back Surgery		Bilateral Tubal Ligation	
CABG (heart bypass)		Breast Biopsy	
Carpal Tunnel Release		Cesarean Section	
Cataract Extraction		D and C	
Cholecystectomy		Hysterectomy	
Colectomy		Mastectomy	
Colostomy		Myomectomy	
Gastric Bypass		TAH/BSO	
Hernia Repair		Vaginal Hysterectomy	
Hip Replacement			
Knee Replacement		Other	
Liver Biopsy		Other	
Pacemaker		Other:	
Small Bowel Resection			
Thyroidectomy			

Health Maintenance – Check if you have completed the following and most recent date.			
Exam	Date	Exam	Date
Breast Exam		GYN Exam	
Cardiac Stress Test		Influenza Vaccine	
Colonoscopy		Mammogram	
DEXA Scan		PAP Test	
Echocardiogram		Physical Exam	
EKG		Pneumococcal Vaccine	
Eye Exam		Sleep Study	
Foot Exam		Tetanus Vaccine	

Family history – Check if any family member(s) has had any of the following conditions.

☐ Unknown

Diagnosis	Mother	Father	Brother	Sister	Other	Other
Alcoholism						
Alzheimer's Disease						
Asthma						
Blood Disease						
CAD (Heart Attack)						
Cancer – Type:						
CVA (Stroke)						
Depression						
Diabetes						
Hyperlipidemia (High Cholesterol)						

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Family history – Check if any family member(s) has had any of the following conditions.						
☐ Unknown						
Diagnosis	Mother	Father	Brother	Sister	Other	Other
Hypertension (High Blood Pressure)						
Irritable Bowel Disease						
Mental Illness						
Obesity						
Osteoarthritis						
Osteoporosis						
PVD						
Renal Disease						
Other:						
Other:						

Social History for Adult Patients

Are you currently working ☐ Yes ☐ No	☐ Retired ☐ Disabled	Employer
Do you have children ☐ Yes ☐ No If yes, how many:		

Tobacco Use ☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ PPD: _____ ☐ Former/Year quit: _____	☐ Chewing ☐ Smokeless ☐ Cigar ☐ Vape ☐ Cigarette ☐ Pipe

Alcohol Use ☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Drinks per day: _____ ☐ Former/Year quit: _____	Drug Use ☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Drinks per day: _____ ☐ Former/Year quit: _____

Exercise Activity ☐ Moderate ☐ Vigorous ☐ Sedentary ☐ Days per week: _____	Sleep Pattern ☐ Changes ☐ No changes

For Pediatric Patients

Patient Resides with	Primary: ☐ Mother ☐ Father ☐ Both Parents ☐ Other: Secondary: ☐ Mother ☐ Father ☐ Both Parents ☐ Other:

Mothers Occupation	Fathers Occupation	Caregivers Occupation
Childcare ☐ Family member ☐ Daycare ☐ Nanny	School ☐ Public/Private school ☐ Homeschool ☐ Not currently enrolled	Risk Behaviors ☐ Exposure to smoke ☐ Current smoker ☐ Alcohol use ☐ Drug use

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The information on this form is accurate to the best of my knowledge. I understand it is my responsibility to notify the office of any changes in the information on this form. I hereby give my consent to Trinity Medical, WNY to use and disclose protected health information about me to carry our treatment, payment and health care operations. I authorize payment of medical benefits to the named physician/practice for services rendered. I understand that I am responsible for any additional fees incurred as a result of placing my account with an outside collection agency.

x _____ Date: _____

Signature of Parent or Parent/Legal Guardian (if patient under 18 years of age)

x _____ Date: _____

Printed Name of person signing if different from patient

Physician Signature _____ Date: _____