THE CENTER FOR MEDICAL HEALING
Patient Registration

Patient Information

Last Name:_____ First Name:_____ Middle Initial: ____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone:_____ Social Security Number:_____

Cell Phone:_____ Date of Birth: _____

E-mail address:_____ Sex: □ male □ female

I authorize use of electronic communications (email/txt msg): Yes No (circle one)

Name of Employer: _____Work Phone: _____
Work Address:_____

Marital Status: □ Single □ Widowed □ Separated □ Divorced
□ Married; Spouse's name: _____
□ Partnered; Partner's name: _____

Who referred you to Dr. Da Silva? _____

In Case of Emergency
Please Call: _____ Relationship: _____Phone: _____

Insurance Information
What is the name of your insurance company? _____
ID number on your insurance card: _____
Name and relationship of insurance holder,(eg. Self, spouse, parent, etc.): _____
Insurance Holder's date of birth (If not yourself): _____
Do you have any secondary insurance? If so, what?_____

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Dr. Annette DaSilva for any services furnished me by the doctor or her designees. **I understand that I will be responsible for any deductibles, co-payments, co-insurance, and non- covered services.** I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services, and to any party performing services of medical receivables on behalf of the doctor's office.

Cancellation Policy
You must provide at least 24 hours notice prior to cancellation of set appointment. Cancellations less than 24 hours prior to set appointment will result in a **$50.00** charge. Please indicate your agreement by signing below.

Signature of Patient: _____ Date: _____

Dr. Annette Da Silva

Date: _____ **Time:** _____

Name: _____

Age: _____

Sex: M F

Handedness: R L

Referral Source: Physician Self Attorney Patient

Employment Status: Employed Unemployed

Date Last Worked: _____

Chief Complaint:

History of Present Illness:

Pain Description Narrative: See pain diagram

Prioritized Area of Pain by Patient:	#1	#2	#3	#4
Frequency:				
Duration:				
Intensity:				
Pattern:				
Warning Signs:				
Radiation:				
Assoc. Symptoms:				
Descriptive Words:				
Pain Scale 0-10:				

Past Medical History: *Injuries/Accidents:* _____

Past Surgical History:

Recent Hospitalizations:

Medications:

	Med	Dose	Freq.
Current			
Past	(See attached)		

Medication Allergies: Med Reaction

Previous Diagnostic Studies

Date	Test	Results

Date: _____ **Time:** _____

Name: _____

Social History:

Marital Status: Single Married Divorce Widowed

Number of Children: _____ Living at Home: _____

Alcohol	No	Yes	# / day	_____	Years: _____
Tobacco:	No	Yes	Pack / day	_____	Years: _____
Recreation Drug Use:	No	Yes	# / day	_____	Years: _____

Family History: significant for:

Review of Systems:

Constitutional Symptoms	fever weight chg	chills appetite	malaise night sweats	fatigability
Head and Neck Symptoms	headaches	Freq: _____	Intens: _____	Type: _____
	dizziness	syncope	head injury	LOC
Respiratory Symptoms	dyspnea hemoptysis	tacypnea expose TB	wheezing sputum	cough
Cardiovascular Symptoms	chest pain	precip. causes:	timing/duration:	
	palpitations prev MI	orthopnea hypertension	edema	claudication
Endocrine Symptoms	thyroid polyuria	parathyroid polydipsea	H/C intolerance	diabetes
Gynecology Symptoms *Female*	Date of last menses: dysmenorrhea	_____ libido	STD's: pregnancies	_____
Male	Freq. of intercourse: libido	_____ infertility	STD's:	_____
Gastrointestinal Symptoms	heartburn hepititis constipation	nausea hemorroids polyps	vomiting gall stones	diarrhea ulcer
Genitourinary Symptoms	dysuria polyuria stress incontinence	urgency hesitancy hematuria	frequency dribbling nephrolithiasis	nocturia loss in force
Musculoskeletal Symptoms	muscle pain fractures	weakness skeletal deform	atrophy joint stiffness/pain	hypertrophy fasciculation
Neurologic Symptoms	seizures cognitive diffs CN deficits	syncope blurred vision tremors	weakness confusion abn of coordination	paralysis abn of sensation
Psychiatric Symptoms	depression hallucinations anxiety	tension sleep walking mood changes	nervousness suicidal thoughts	anger/irritability diff concentration
Sleep Disturbances	diff falling asleep avg #/nt.:	medication needed _____	nocturnal awake/#	