Date: _____

Miller Heights Medical Associates

Brian D. Kuronya D.O.

Vasumathy Kumaresan M.D.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ Nickname: _____

Date of Birth: _____ Social Security # _____

Sex: (circle one) Male/Female Marital Status: (circle one) Single Married Divorced Widowed

Patient's Best Phone Number to Contact: _____

Patient Street Address: _____

City, State, Zip: _____

Mailing/Billing Address: _____

City, State, Zip: _____

Emergency Contact:

Name: _____ Relationship: _____

Best Phone Numbers to Contact: _____

Name: _____ Relationship: _____

Best Phone Numbers to Contact: _____

How did you hear about Miller Heights Medical? _____

Interested in Patient Portal: **Yes or** No **Email**: _____

I authorize my medical information may be shared with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Policy # _____ Group # _____

Insured's Name: _____ Relation: _____

Insured's Date of Birth: _____ Social Security #: _____

Secondary Insurance Company Name: _____

Policy #: _____ Group # _____

Insured's Name: _____ Relation: _____

Insured's Date of Birth: _____ Social Security #: _____

Assignment and Release of Information Statement

I acknowledge that the information that I have provided is true and correct. I hereby authorize my insurance carrier to make payment directly to Miller Heights Medical Associates for services rendered to me or my dependents. I understand that I am fully responsible for any charges incurred for services rendered as well as any costs or fees incurred for collection of this account. I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents.

Patient Name (print): _____ Signature: _____

Relationship to Patient: _____ Date: _____

Miller Heights Medical Associates

Medical History

Patient Name: _____ Date of Birth: _____

Allergies to Medications, X-Rays/dye, or Food: (if yes, please list name of medicine and type of reaction)

_____ _____

_____ _____

_____ _____

Medications: (prescriptions, over the counter, vitamins, supplements, herbs, etc)

Name of Medication	Dose

Gynecologic and Obstetric History

Age of onset of periods: _____ Frequency: _____ Length: _____

Number of Pregnancies: _____ Births: _____ Miscarriages: _____

Full Term Deliveries: _____ Vaginal Delivery: _____ C-Section: _____

Prolonged and abnormal bleeding: Yes/No If yes explain: _____

Leakage of Urine: Yes/No If yes explain: _____

Pelvic Pain: Yes/No If yes explain: _____

Abnormal Discharge: Yes/No If yes explain: _____

History of abnormal Pap smear: Yes/No If yes explain: _____

Hospitalizations/Operations: (What type of operation and month/year? (Hospitalization Reason month/year.)

Operations: _____ _____

_____

_____

Hospitalizations: _____ _____

_____ _____

Immunizations:

Pneumovax	Yes/No	Date Received Vaccine: _____
Flu	Yes/No	Date Received Vaccine: _____
Tetanus	Yes/No	Date Received Vaccine: _____
Hepatitis B	Yes/No	Date Received Vaccine: _____

Past Medical History: (please list doctor diagnosed medical problems)

_____

_____

_____

_____

_____

Family History: (siblings, parents, grandparents and whether it is Maternal (mother) or Paternal (father) side)

Illness	Family Member-Relation/Maternal or Paternal	Age	Circle One
Bleeding Diseases	_____	____	Alive/Deceased
Cancer (Type)	_____	____	Alive/Deceased
Diabetes	_____	____	Alive/Deceased
Heart Disease	_____	____	Alive/Deceased
Hypertension (High Blood Pressure)	_____	____	Alive/Deceased
Anxiety/Depression	_____	____	Alive/Deceased
Stroke	_____	____	Alive/Deceased

Prevention:

Do you wear seat belts? Yes/No

Do you smoke? Yes/No If yes, how many packs of cigarettes/day? _____

Do you smoke cigars? Yes/No If yes, how many/day? _____

Do you use vaping devices? Yes/No If yes, how much/day? _____

Do you drink alcoholic beverages? Yes/No If yes, how much/week/type? _____

Do you drink caffeinated beverages? Yes/No If yes, how much/day/type? _____

Have you ever worked with chemicals, Asbestos, or other hazardous materials?

Yes/No If yes please Explain: _____

Do you use drugs? (Marijuana, cocaine, crack, etc) Yes/No If yes Explain: _____

Do you engage in any sexual activities that would put you at risk for venereal diseases or AIDS/HIV? Yes/No

Patient Name (print): _____ Patient Signature: _____

Relationship to Patient: _____ Date: _____