Southwest Medical™
Part of OptumCare™

New Patient Registration and Questionnaire SECTION 1

Patient Information

Name:		MRN:
AKA:		Sex: ☐ M ☐ F
Birth Date:	Marital Status:	Preferred Method of Contact: ☐ Email ☐ Mail ☐ Text ☐ Phone
Email Address:		
Address 1:	Home Phone:	
Address 2:	Mobile:	
City, State:	Zip:	

Guarantor Information (Person Responsible for Bill)

Guarantor Name:	
Relation to Guarantor: ☐ Parent ☐ Sibling ☐ Child ☐ Aunt/Uncle ☐ Legal Guardian ☐ Other	
Address:	Telephone #:
City, State:	Zip:

Patient Employer Information		Guarantor Employer Information	
Employer:		Employer:	
Address 1:		Address 1:	
Address 2:	Telephone #	Address 2:	Telephone #:
City, State:	Zip:	City, State:	Zip:

Emergency Contact Information

Name:	Relation:
Address:	
City, State:	Zip:
Home Telephone #:	Mobile #:

Insurance Information

Primary Insurance:	Subscriber Name:	DOB:
	ID Number:	
Secondary Insurance:	Subscriber Name:	DOB:
	ID Number:	
Tertiary Insurance:	Subscriber Name:	DOB:
	ID Number:	

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New Patient Registration and Questionnaire SECTION 2

1. Demographic

Race	Ethnicity
☐ White ☐ African American/Black ☐ American Indian ☐ Pacific Islander ☐ Other ☐ Decline ☐ Unknown	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other ☐ Unknown
Do you need a translator? ☐ Y ☐ N	Primary spoken language:
Do you have an Advance Directive? : ☐ Y ☐ N	Are you hearing impaired? ☐ Y ☐ N

2. Health Maintenance

a. When was the last time you had the following tests performed? (please check all that apply)

	Past Year	2 Years	10 years	Never
Colonoscopy				
Routine Physical				
Eye Exam				
Breathing Test				
Bone Density				
Cholesterol Check				
Flu Shot				
Pneumonia Vaccine				
Women's Health				
Mammogram				
PAP Smear				

3. Past Medical History

a. Do you have or have you ever been diagnosed with: (If yes, please specify how long ago)

	Yes	No	0 – 12 months	1 – 3 years	3 - 5 years	5 – 10 years	10+ years
Diabetes							
High Blood Pressure							
Heart Disease							
High Cholesterol							
Cancer							
Stroke							
Seizures							
Lung Disease (Asthma, COPD, etc.)							
Glaucoma							
HIV							
Other(s):							

New Patient Registration and Questionnaire SECTION 2

b. Have you been hospitalized in the past year? ☐ Y ☐ N (If yes, please specify below)

Date	Hospital	Reason

For additional space, please use page 5 addendum 3b

c. Do you see any specialists? ☐ Y ☐ N If yes, please provide the name and reason:

Specialist Name	Reason

For additional space, please use page 5 addendum 3c

4. Past Surgical History

Have you ever had surgery? ☐ Y ☐ N If Yes, please explain:

Date	Procedure	Reason

For additional space, please use page 5 addendum 4

5. Family History

	Yes	No	Relation (e.g. father)
Diabetes			
High Blood Pressure (Hypertension)			
Heart Disease			
High Cholesterol			
Cancer			
Stroke			
Seizures			
Lung Disease (Asthma, COPD, etc.)			
Other(s):			

6. Social History

a. What is your smoking status? Never_____Past Smoker_____Current Smoker_____

How many packs per day? _____ How many years of smoking history? ____

b. Do you drink alcoholic beverages? ☐ Y ☐ N If yes, approx. # drinks per week: _____

c. Have you or do you use any drugs for recreational use (confidential): ☐ Y ☐ N

If yes, please explain: _____

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d. Have you been exposed to any conditions/events that could potentially be damaging to your health (i.e. military combat, occupational hazards, etc.)? If yes, please explain: _____

_____

_____

7. Allergies

Do you have any food or drug allergies? ☐ Y ☐ N If yes, please list and describe:

Food or Drug	Reaction

For additional space, please use page 5 addendum 7

8. Medications

Please list all medications, including over the counter "OTC" medications and herbal supplements that you are currently taking or have taken in the last 12 months:

Drug, OTC, or Herbal Supplement	Currently Taking?		Dose	Treatment Purpose
	Yes	No		

For additional space, please use page 5 addendum 8

9. Pharmacy Information

Please provide us with the name and location of your preferred pharmacy:

Name: _____ Phone: _____

Location: _____

10. Patient/Provider Review

Please sign below to confirm that the information above is accurate and has been reviewed.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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New Patient Registration and Questionnaire SECTION 2

Addendum

3.b Past Hospitalizations

Date	Hospital	Reason

3.c Current Specialists

Specialist Name	Reason

4. Past Surgical History

Date	Procedure	Reason

7. Allergies

Food or Drug	Reaction

8. Medications

Drug, OTC, or Herbal Supplement	Currently Taking?		Dose	Treatment Purpose
	Yes	No		