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vista medical associates

www.vistamedcare.com

PATIENT REGISTRATION

Note: This form may be completed manually or on your computer. To complete this form on your computer: 1. Type your answer in each field. 2. Save your work often on your computer or device. 3. Email your completed packet, along with a picture of the front and back of your insurance card(s) to office@vistamedcare.com.

Patient Information

Name (Last, First, MI)	SSN	Birthdate	
Language	Gender	Email	
Billing Address (Street, Apt. or Unit #	City	State	Zip
Physical Address if different from Billing Address	City	State	Zip
Cell Phone	Home Phone	Day Phone	Preferred Method of Contact ☐ Cell ☐ Home ☐ Day ☐ Email
Marital Status	Mother's Maiden Name	Race	Ethnicity
Emergency Contact	Phone Number		
Employer	Address		
Phone Number	Occupation		

Policyholder/Guarantor (If different than patient)

Name (Last, First, MI)	SSN	Birthdate	
Language	Gender	Email	
Billing Address (Street, Apt. or Unit #	City	State	Zip
Physical Address if different from Billing Address	City	State	Zip
Cell Phone	Home Phone	Day Phone	Preferred Method of Contact ☐ Cell ☐ Home ☐ Day ☐ Email
Marital Status	Mother's Maiden Name	Race	Ethnicity
Relationship to Patient			

Patient Name			Birthdate		
Primary Insurance					
Name of Insurance Company			Policy Number		
Name of Policyholder	DOB	Relationship to Patient	Group #	Copay Amt. $	Deductible Amt. $
Address of Insurance Co.		Phone	Effective Date		Expiration Date
Secondary Insurance					
Name of Insurance Company			Policy Number		
Name of Policyholder	DOB	Relationship to Patient	Group #	Copay Amt. $	Deductible Amt. $
Address of Insurance Co.		Phone	Effective Date		Expiration Date

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.
CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Vista Medical Associates to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.
ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Vista Medical Associates.

_____ _____ _____

Patient/Guardian Signature | Date | Relationship to Patient

This space is intentionally blank.

Patient Name	Birthdate

Preferred Pharmacy	
Local	Mail Order

Current Medications		
Medication	Dose	Frequency

Please list all allergies		
List all medication allergies	☐	Seasonal
	☐	Grasses
	☐	Animals
	☐	Food _____
	☐	Intolerance _____

Vaccines (indicate most recent date)	
☐ Tdap	Date:
☐ Prevnar 20	Date:
☐ Shingrix	Date:
☐ Covid	Date:
☐ Flu	Date:

Previous PCP and Current Specialists	
Previous PCP Name	Phone #
Specialist Name	Specialty

Health Maintenance History					
Annual Physical		Date:			
Bone Density		Date:			
Mammogram	Date:	☐	Normal	☐	Abnormal
Pap Smear	Date:	☐	Normal	☐	Abnormal
Colonoscopy	Date:	☐	Normal	☐	Abnormal

Patient Name	Birthdate

Have you experienced any of these symptoms recently? (Check all that apply)

☐ Fever/Chills/Sweats	☐ Fatigue	☐ Night Sweats
☐ Dizziness	☐ Anxiety	☐ Depression
☐ Nausea/Vomiting	☐ Diarrhea	☐ Constipation
☐ Changes in Bladder Habits/Control	☐ Burning with Urination	☐ Blood in Urine ☐ Stool
☐ Changes in Bowel Habits/Control	☐ Easy Bruising	☐ Easy Bleeding
☐ Cold Intolerance	☐ Heat Intolerance	☐ Food Allergies
☐ Rash	☐ Itching	☐ Environmental Allergies
☐ Chest Pain	☐ Palpitations	☐ Leg Cramps w/Exercise
☐ Shortness of Breath	☐ Cough	☐ Back Pain
☐ Vision Changes	☐ Headaches	☐ Joint Pain
☐ Poor Balance/Falls	☐ Unusual Weakness	☐ Difficulty Swallowing
☐ Memory Problems	☐ Confusion/Brain Fog	☐ Difficulty Speaking
☐ Numbness/Tingling	☐ Unexplained Weight Gain/ Loss	☐ Increased Pain at Night/Rest
☐ Change in Appetite	☐ Suicidal Ideation	☐ Other: _____

Please check any condition you currently have OR have ever had in the past.

☐ **Click here if you have NONE of these conditions**

☐ Asthma	☐ Anxiety	☐ Stroke
☐ Cancer:	☐ Seizures	☐ Pacemaker
☐ Diabetes	☐ Hepatitis	☐ Heart Attack
☐ Blood Clot	☐ Liver Disease	☐ Valvular Heart Disease
☐ Anemia	☐ Concussion	☐ Coronary Heart Disease
☐ Osteoporosis/Osteopenia	☐ STI	☐ Infectious Disease
☐ Pins or Metal Implants	☐ Hernia	☐ Sleep Problems
☐ Arthritis	☐ Visual Dysfunction	☐ Edema
☐ Epilepsy	☐ Neurologic Disorder	☐ Breathing Problems
☐ COPD	☐ Low Blood Pressure	☐ Migraines/Headaches
☐ Pneumonia	☐ High Blood Pressure	☐ Hypo/Hyperthyroidism
☐ High Cholesterol	☐ Gallstones	☐ Lupus
☐ Anemia	☐ Heartburn/Reflux	☐ Frequent UTI
☐ Frequent Sinus Infections	☐ Ulcers	☐ Kidney Stones
☐ Glaucoma or Eye Disease	☐ Chrohns/Colitis	☐ Kidney Disease
☐ Polio	☐ Head Injury	☐ Chicken Pox/Shingles
☐ Fibromyalgia	☐ Enlarged Prostate	☐ Alzheimers/Dementia
☐ Tuberculosis		

Please list any additional conditions not mentioned above:

Patient Name	Birthdate

Past Surgical History (If applicable, please check the box and enter the year)

Surgery	Year	Surgery	Year	Surgery	Year
☐ Eyes (Laser/Vision Correction)		☐ Gall Bladder		☐ Spinal Surgery/Back	
☐ Eyes (Cataract/Glaucoma)		☐ Intestine/Colon		☐ Orthopedic (Hips/Knees)	
☐ Ears		☐ Hemorrhoids		☐ Shoulders/Feet/Hands	
☐ Sinus/Nasal Septum		☐ Hernia		☐ C-Section	
☐ Tonsils/Adenoid		☐ Breast		☐ Vasectomy	
☐ Thyroid		☐ Uterus/Hysterectomy		☐ Tubal Ligation	
☐ Heart		☐ Ovaries		☐ Prostate	
☐ Stomach		☐ Spinal Surgery/Neck		☐ Varicose Veins	

Other Surgeries:

Gynecological/Obstetrical History

Age when you started menstruating:	Menstrual cycles ☐ Regular ☐ Irregular
Painful periods? ☐ Yes ☐ No	Age at menopause:
Date of last mammogram:	Date of last Pap Smear:
History of abnormal mammogram? ☐ Yes ☐ No	History of abnormal Pap? ☐ Yes ☐ No
Number of pregnancies:	Number of live births:
Number of miscarriages:	Method of contraception:

Tobacco/Alcohol/Drug Use History

Tobacco use: ☐ Yes ☐ No	Alcohol use: ☐ Yes ☐ No	Drug use: ☐ Yes ☐ No
If yes, how many packs a day?	If yes, how many drinks a day/week?	If yes, drug of choice?
Have you ever quit? ☐ Yes ☐ No	Has anyone told you have a drinking problem? ☐ Yes ☐ No	Have you ever used needles? ☐ Yes ☐ No

Advance Directive

Do you have an Advance Directive? ☐ Yes ☐ No If yes, please bring it to your appointment.
Would you like to discuss Advance Directives? ☐ Yes ☐ No

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Patient Name	Birthdate

Family Medical History			
Disease	Relation	Disease	Relation
☐ Cancer _____		☐ Osteoporosis	
☐ Diabetes		☐ Cystic Fibrosis	
☐ Cardiac/Dysrhythmia		☐ Asthma	
☐ Congestive Heart Failure		☐ Peptic Ulcer	
☐ Coronary Artery Disease		☐ Gallstones	
☐ Valvular Heart Disease		☐ Crohn's/Colitis	
☐ High Blood Pressure		☐ Alzheimer's	
☐ High Cholesterol		☐ Alcoholism	
☐ Stroke		☐ Bleeding Tendency	
☐ Kidney Stones		☐ Anemia	
☐ Kidney Disease		☐ Gout	
☐ Dialysis		☐ Depression	
☐ Chronic Lung Disease		☐ Mental Illness	
☐ Tuberculosis		☐ Seizures	
☐ Rheumatoid Arthritis		☐ Migraine Headaches	
☐ Thyroid Issues		☐ Other _____	

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