VonStieff MEDICAL GROUP

New Patient Form

*** Please note - There is a $25.00 NO-SHOW FEE for any missed appointment ***

Name: _____
Last First Middle Initial

SSN: _____ Birth Date: ___/___/_____

Allergies

1 _____
2 _____
3 _____
4 _____

Previous Surgery

1 _____
2 _____
3 _____
4 _____

Current Medications

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____

Chronic Problem List

1 _____
2 _____
3 _____
4 _____

Race

- ☐ American Indian
- ☐ Asian
- ☐ Black / African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Pacific Islander
- ☐ Other

Dates of Last Procedures (if known)

PAP (women only): ___/___/_____
MAMMO (women only): ___/___/_____
Colonoscopy: ___/___/_____
EKG: ___/___/_____

Dates of Last Immunizations (if known)

Tetanus/TDAP: ___/___/_____
Pneumovax: ___/___/_____
Colonoscopy: ___/___/_____
EKG: ___/___/_____
Hep A: ___/___/_____
Hep B: ___/___/_____
TB: ___/___/_____

Medical Alerts

1 _____
2 _____
3 _____
4 _____

List father's diseases: _____

_____

List mother's diseases: _____

_____

Do you have, or have you had, any of the following:

High cholesterol?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Heart & vascular disease		
Chest pain?	☐ Yes	☐ No
Heart attack?	☐ Yes	☐ No
Stroke?	☐ Yes	☐ No
High blood pressure?	☐ Yes	☐ No
Pacemaker?	☐ Yes	☐ No
Valve problem?	☐ Yes	☐ No
Swelling of legs?	☐ Yes	☐ No
Cancer?	☐ Yes	☐ No
Alcohol or drug problem?	☐ Yes	☐ No
Which one? _____		
Do you smoke?	☐ Yes	☐ No
For how long? _____		
How much? _____		
Respiratory disease	☐ Yes	☐ No
Emphysema?	☐ Yes	☐ No
Bronchitis?	☐ Yes	☐ No
Bronchial asthma?	☐ Yes	☐ No
Sleep apnea?	☐ Yes	☐ No
If yes, do you have a C-PAP?	☐ Yes	☐ No
If yes, do you use it?	☐ Yes	☐ No
Anemia requiring medical treatment?	☐ Yes	☐ No
Seizure disorder?	☐ Yes	☐ No
Prostate disorder?	☐ Yes	☐ No

Any additional health information that we should know about?

_____

_____

_____

_____

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Please visit us online at www.vsmedicalgroup.com

Patient Registration

Patient Information

Last Name	First Name	Middle Initial

Date of Birth	SSN

Cell Phone	Home Phone	Work Phone

Email Address

Street Address

City	State	Zip

Please check all that apply	☐ Single ☐ Married	☐ Divorced ☐ Separated	☐ Widowed	☐ Minor ☐ Student

Employer Information

Employer Name	Work Phone

Emergency Contact

Name	Relation

Cell Phone	Home Phone	Other Phone

Insurance Information

All insurance information must be completed. We will make a copy of your insurance card.
If we have made a copy of your insurance card, this section does not need to be completed.
If you are not the card holder, this information must be completed.

Primary Insurance

Primary Insurance	Policy Holder Name

ID Number	Group Number

Policy Holder DOB	Policy Holder SSN

Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Dependent

Secondary Insurance

Primary Insurance	Policy Holder Name

ID Number	Group Number

Policy Holder DOB	Policy Holder SSN

Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Dependent

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