New Patient Registration

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: Home: _____

_____ Mobile: _____

_____ Work: _____

Email address: _____

Insurance Carrier: _____

With your permission, we would like a copy of your insurance card for your chart. Although Dr. Knowles does not accept insurance payments for services, the information is sometimes necessary for ordering tests and making referrals.

Preferred Pharmacy - Local: _____

Mail Order *(if used)*: _____

Emergency Contact: _____

Phone: _____ Relationship to Patient: _____

Medications/Supplements You are Currently Taking:

Name	*Strength/Dose*	*Frequency*

Allergies to Medications or Other Substances:

Name *Reaction*

_____

_____

_____

Medical Problems/Diagnoses - *(circle all that apply)*:

High blood pressure	Pneumonia	Drug abuse
Heart disease	Sleep apnea	Dementia/memory loss
Heart attack/MI	Neuropathy	Parkinson's disease
Congestive Heart failure	Fibromyalgia	Multiple sclerosis
Atrial fibrillation	Rheumatoid arthritis	Seizure
Vascular disease	Osteoarthritis	Seasonal allergies
Aneurysm	Gout	Chronic sinusitis
Stroke	Lupus	Glaucoma
High cholesterol	Lyme disease	Macular degeneration
Diabetes	GERD/Acid reflux	Kidney disease
Thyroid disease	Ulcer	Kidney stones
Vitamin D deficiency	Liver disease	Enlarged prostate
Osteoporosis	Crohn's disease	Erectile dysfunction
Blood clots	Ulcerative colitis	Abnormal menstrual periods
Bleeding disorder	Chronic constipation/diarrhea	Polycystic ovaries
Anemia	Gallstones/gallbladder disease	Chronic pain
Leukemia	Pancreatitis	ADHD
Cancer	Chronic headaches/migraine	Eczema
HIV/AIDS	Anxiety/depression	Rosacea
Asthma	Bipolar disorder	Psoriasis
COPD/Emphysema	Chronic insomnia	Skin cancer
COVID-19	Alcoholism	Herpes zoster (shingles)

Most recent colonoscopy:

Most recent mammogram:

Vaccine History

COVID-19	Date(s):
Influenza	Date of most recent:
Pneumococcal (pneumonia)	Date(s):
Hepatitis	Date(s):
Herpes zoster (shingles)	Date(s):
Tetanus	Date(s):

Surgical History

Name of Procedure *Approximate Date*

_____

_____

_____

_____

_____

Social History

Occupation/Job: _____

Marital Status: _____ Number of children: _____

Name of Spouse: _____

Do you currently use tobacco products, smoke, or vape? *(please circle one)* Yes No

If yes, what? *(circle all that apply)* Cigarettes Cigars Marijuana Dip/chew Vape Other

How much per day? _____ How long? _____If quit, when? _____

Alcohol consumption *(please circle one)*: none occasional regular heavy

Substance/drug abuse *(circle all that apply)*: none marijuana meth heroin cocaine other

Family History

Relationship *Condition*

_____

_____

_____

_____

_____

_____

Previous Primary Care Provider: _____

City/State: _____ Phone: _____

Other Providers (Consultants or Specialists) Involved in Your Care:

Name *Specialty* *Location*

_____

_____

_____