

# PINNACLE MEDICAL GROUP

## Island Family Physicians

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### PATIENT REGISTRATION FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(last) (First) (MI)

Local Address: \_\_\_\_\_ (Street and PO Box if applicable)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Permanent Address: \_\_\_\_\_ (Street and PO Box if applicable)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Race:  American Indian or Alaska Native  Asian  
 Native Hawaiian or Other Pacific Islander  White  
 Black or African American  Unreported/Refused to Report

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Social Security #: \_\_\_\_\_ Medicare #: \_\_\_\_\_ (if applicable)

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Primary / Secondary Insurance Company: \_\_\_\_\_  
(Be prepared to provide your insurance cards so we may photocopy them.)

Claims Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Ins ID # \_\_\_\_\_ Group # \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

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**ADULT HISTORY RECORD – CONFIDENTIAL**

**PERSONAL HISTORY**

Your Name \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Person to contact in an emergency \_\_\_\_\_ Relationship to you \_\_\_\_\_

Their work phone \_\_\_\_\_ Their home phone \_\_\_\_\_

Marital History  Married # years \_\_\_\_\_  
 # times \_\_\_\_\_  
 Separated  
 Divorced  
 Widowed

Level of Education \_\_\_\_\_ Religious preference \_\_\_\_\_

Alcohol use  Never  Occasional  Weekends  Daily  
Tobacco use Number of years \_\_\_\_\_  
Packs per day \_\_\_\_\_

Are you employed?  Yes  No  
List type of work you have been involved in \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I was referred by \_\_\_\_\_

**ILLNESSES**

Check  where you or members of your family have had the following illnesses or problems

- |                          |                          |   |
|--------------------------|--------------------------|---|
| You                      | Your Family              |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, tumor                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cholesterol                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug abuse                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema, hives, rashes                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, seizures                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye problems                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease                             |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney/bladder problems                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease, hepatitis, yellow jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease, tuberculosis                |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps, measles, chicken pox               |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervous breakdown, mental illness         |
| <input type="checkbox"/> | <input type="checkbox"/> | Phlebitis                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Rubella, German measles                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Suicide attempt                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer in stomach, duodenum                |
| <input type="checkbox"/> | <input type="checkbox"/> | Uncontrolled bleeding                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____                               |
| <input type="checkbox"/> | <input type="checkbox"/> | _____                                     |

**MEDICINES**

Include birth control pills or vitamins, with or without a prescription

- \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

Drugs and other allergies

- \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMMUNIZATIONS**

- Measles shot Year \_\_\_\_\_  
Tetanus shot Year \_\_\_\_\_  
Pneumonia shot Year \_\_\_\_\_  
Flu shot Year \_\_\_\_\_  
Year \_\_\_\_\_  
Year \_\_\_\_\_

**HOSPITALIZATIONS**

Serious illness, injuries or surgeries and year.

Do not list normal pregnancies.

- Year \_\_\_\_\_  
Year \_\_\_\_\_  
Year \_\_\_\_\_  
Year \_\_\_\_\_  
Year \_\_\_\_\_

**PREGNANCY HISTORY**

Enter number of times \_\_\_\_\_ Premature \_\_\_\_\_

Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_ Live Births \_\_\_\_\_ Living children \_\_\_\_\_

**HEALTHCARE PROVIDERS**

List physicians you have see in the past 5 years.

Year	Name	City, State	Problem cared for
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PINNACLE MEDICAL GROUP**  
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**Patient Consent to Receive Mail, Telephone  
and/or E-mail Message**

DOB: \_\_\_\_\_  
Please print (Last Name) (First Name) (M.I.)

**Do we have permission to?**

Send a yearly appointment card to your home? Yes  No

Send test results to your home? Yes  No

Send test results to your email? Yes  No

Email address: \_\_\_\_\_

**Leave the following information on your home answering machine/voice mail/email:**

Appointment information Yes  No

Billing information Yes  No

Medical information Yes  No

**Leave the following information on your work answering machine/voice mail:**

Appointment information Yes  No

Billing information Yes  No

Medical information Yes  No

**I give permission to share appointment information with the person named below:**

Name: \_\_\_\_\_

**I give permission to share medical information (including biopsy/lab results, prescriptions, etc.) with the person(s) listed below:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

**I give permission to share billing information with the person listed below:**

Name: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

*For internal purposes only - Account No:*