REGISTRATION-ESTABLISHED PATIENTS

Joanne Crenshaw, M.D
Shaleen Belani, M.D.

Date: _____

Last Name _____ First Name _____ M.I. ____ Sex: M ___ F ___

Email: _____ (Your email gives you access to the patient portal to access/update your medical records.)

Local Pharmacy Name: _____ City: _____ Phone: _____
(Not mail order pharmacy)

Primary Medical Doctor's Name/Address/Phone: _____

Referring Provider's Name/Address/Phone (if different than above): _____

***Language**: English: ___ Other: ___ Decline response ___

***Ethnicity**: Hispanic ___ Non-Hispanic ___ Decline response ___

***Race**: White ___ Black/African American ___
Asian ___ American Indian/Alaska Native___
Native Hawaiian/Other Pacific Islander___
Decline response___

Person(s) you would like to authorize to receive/discuss medical information: _____
Person to contact in case of an emergency: _____ Relationship/phone#: _____

I hereby authorize Joanne Crenshaw, MD, PC to apply for benefits on my behalf for services rendered and authorize the release of any information acquired in the course of my treatment necessary to process insurance claims. I request payment from the above indicated insurance carrier to be made directly to Joanne Crenshaw, MD, PC, realizing that I am responsible for all non-covered charges. I also realize I am responsible for any other costs incurred while collecting my outstanding balance(s). I acknowledge their notice of privacy practices is available to me upon request. I certify that the information I have reported is correct to the best of my knowledge. This is to remain in effect indefinitely unless revoked in writing by the undersigned.

Patient, Parent or Guardian Signature: _____ Date: _____

Name: _____ **Date:**_____

MEDICAL HISTORY UPDATE

Medications you currently take:

_____

_____

_____

Allergies to medications:

___ NONE; IF YES, please list: _____

List all major illnesses and surgeries since your last visit: _____

_____

Current eye problems: _____

_____

REVIEW OF CURRENT HEALTH:	YES	NO	DETAILS
GENERAL (fever, weight loss, malaise...)	___	___	_____
EAR/NOSE/THROAT (stuffy nose, ear ache, cough, dry mouth...)	___	___	_____
CARDIOVASCULAR (chest pain, racing pulse...)	___	___	_____
RESPIRATORY (congestion, wheezing...)	___	___	_____
GASTROINTESTINAL (stomach upset, diarrhea, constipation)	___	___	_____
GENITOURINARY (urinary flow problems)	___	___	_____
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling)	___	___	_____
SKIN (rashes, suspicious growths)	___	___	_____
NEUROLOGICAL (headache, numbness, paresthesias)	___	___	_____
PSYCHIATRIC (depression, anxiety)	___	___	_____
ENDOCRINE (hot/cold intolerance)	___	___	_____
HEMATOLOGIC (bleeding disorder, anemia)	___	___	_____
ALLERIC/IMMUNOLOGIC (sneezing, swollen nodes, hives)	___	___	_____

Family History	Mother	Father	Sister	Brother	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Glaucoma	___	___	___	___	___	___	___	___
Macular degeneration	___	___	___	___	___	___	___	___
Retinal detachment	___	___	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___	___	___
Hypertension	___	___	___	___	___	___	___	___
Stroke	___	___	___	___	___	___	___	___
Thyroid disease	___	___	___	___	___	___	___	___
Cancer	___	___	___	___	___	___	___	___
Other	___	___	___	___	___	___	___	___

Social History

Smoking: ___ never smoker
___ current smoker (___ packs per day)
___ former smoker (___ pack years)

Alcohol: ___ Yes ___ No; If yes, how much per week? _____

Drug use: ___ Yes ___ No