Javier B Cairo MD, MPH
Infectious Disease Specialist
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PATIENT REGISTRATION FORM

Please print all information and use legal name on insurance card.

Patient Information:

Last Name_____ First Name_____ MI_____

D.O.B: _____ SS#: _____ Sex: ____Male ____Female

Mailing Address_____

Street apt#

_____

City State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred Language: _____ Do you have a Living Will or Advanced Directive? Yes - No

Ethnicity (circle): Hispanic- Non- Hispanic- Unknown Race (circle): Black - White - Asian - Hispanic - Other

Employment Status: __Full Time __Part Time __Retired __Unemployed __Other _____

Employer Name_____Occupation_____

Employer Address: _____ phone#_____

Marital Status: __ Single __Married __Divorced __ Widowed Other_____

Spouse/Parent Name_____D.O.B_____Phone_____

Emergency Contact Name: _____ Phone: _____ Relationship to Patient_____

How did you hear about use? (Please circle)
Newspaper Friend Family Hospital Insurance Plan Yellow Pages Internet
Other: _____

Insurance Information
** PROVIDE INSURANCE CARD TO THE FRONT DESK **

Primary Insurance: _____ Phone #: _____
Policy #: _____ Group #: _____
Policy Holder's Name: _____ Relationship to Patient: _____
Policy Holder's D.O.B _____ Policy Holder's SS#:_____

Secondary Insurance: _____ Phone #: _____
Policy #: _____ Group #: _____
Policy Holder's Name: _____ Relationship to Patient: _____
Policy Holder's D.O.B _____ Policy Holder's SS#:_____

Patients Name:

_____D.O.B._____

Health Information

Please check any and all medical problems that may apply.

__ High Blood Pressure	__ COPD	__ Diabetes
__ High Cholesterol	__ Asthma	__ Thyroid
__ Heart Problems	__ Other Lung Disease	__ Anemia
__ Glaucoma	__ Sinus Problems	__ Kidney Problems
__ Stroke	__ Allergies	__ Kidney Disease/Stones
__ Seizures	__ Acid Reflux (GERD)	__ Urinary problems
__ Headaches/Migraines	__ Gastritis	__ Prostate Disease
__ Depression/Anxiety	__ Gallbladder Disease	__ Constipation
__ Vascular Disease	__ Hepatitis/Liver Disease	__ Skin Problem
__ Cancer (where?)_____	__ Diverticulosis	

List Any Other Medical Problems:

_____
_____
_____

Please List Any Surgeries/Hospitalizations (including Year)

_____/_____
_____/_____
_____/_____
_____/_____
_____/_____

Allergies: Please list any allergies and reaction to them, if you have no allergies please write NONE.

_____
_____
_____
_____

Medication List

Medication:	Dosage:	Frequency:
1)	/	/
2)	/	/
3)	/	/
4)	/	/
5)	/	/
6)	/	/
7)	/	/
8)	/	/
9)	/	/
10)	/	/

Patients Name:

_____D.O.B._____

Social History

Tobacco Use _____ a day, number of years _____ Year Quit _____
Alcohol Use _____ drink per week
Street Drugs _____
Exercise _____ type, low fat diet? _____
Drink Water _____ cups per day
Caffeine _____ cups per day
Sleep well? _____

Preventive Care

Colonoscopy? _____ Date _____ Results/Findings _____
Rectal Exam? _____ Date_____ Results/Findings _____
Fecal Occult Blood Test_____ Date_____ Results/Findings _____
Glaucoma Testing _____ Date_____ Results/Findings _____

Immunizations

Flu shot_____Date_____
Pneumonia shot_____ Date_____
Tetanus shot_____ Date_____
Hepatitis B shot_____ Date_____
Shingles shot_____Date_____

Pharmacy name: _____ Number_____

Primary Care Physician: _____ Number _____