Integrative Care, LLC
10404 W. Coggins Dr. Sun city, AZ 85351
P (623) 972-1055 F (623) 972-1185

PATIENT REGISTRATION

First Name:_____ Last Name:_____ Middle Initial:_____

DOB:_____ Social Security #_____

Home Address:_____City_____State_____Zip_____

Home Phone:_____ Cell Phone:_____

Sex: Male___ Female_____ Marital Status: Married_____ Single_____ Widowed_____ Divorced_____

(Policy Holder Information)

First Name:_____ Last Name:_____ Middle Initial:_____

DOB:_____ Social Security #_____

Home Address:_____City_____State_____Zip_____

Home Phone:_____ Cell Phone:_____

Primary Insurance

Insurance Name_____

Policy #_____

Group #_____

Insurance Phone_____

Secondary Insurance

Insurance Name_____

Policy #_____

Group #_____

Insurance Phone_____

Do you have a third insurance? Yes No, If yes what insurance

Insurance Info_____

Past Medical History

Alcoholism, Chest Pain, Back Pain, Neck Pain, Migraines, Headaches, Arthritis, Hepatitis, Bronchitis, Sinusitis, Pancreatitis, Blood Disease, Heart Disease, Skin Disease, Thyroid disease, Liver Disease/ Cirrhosis, Venereal Disease, Cancer, Tumor, Stroke, Heart Attack, High Blood Pressure, Diabetes, Depression, Lung Problem, Kidney Problem, Psychiatric Problems, Gallstones, German Measles, Glaucoma, Gout, Fibromyalgia, Fibrocystic Breast, Emphysema, Epilepsy, Hemorrhoids, Hernias HIV,UTI infections, other_____

Surgical History

Type and year_____

_____

_____

Preventive care

Women

Last Pap smear_____

Last mammogram_____

Men

Last Prostate_____

Last colonoscopy_____

Social history

Tobacco use: Yes or No

Alcohol use: Yes or No

Do you drink caffeine: Yes or No

Do you use recreational drugs: Yes or No

Do you practice safe sex? Yes or No

Do you wear a seat belt? Yes or No