SOUTHERN COOS HOSPITAL & HEALTH CENTER

Quality Healthcare With a Personal Touch

Patient Registration Form

Patient Demographic Information

Patient Name: (Last, First, M.I.)		Social Security Number: ___ - ___ - ____	Preferred Name:
Date of Birth: (M / D / YY)	Sex at Birth: ☐Male ☐Female	Mailing Address: City: State: Zip:	
Gender Identity:	Religion:	Home Address: City: State: Zip: ☐Same as above	
Ethnicity: ☐ Non-Hispanic/Latino/Latina ☐ Hispanic/Latino/Latina	Race: ☐White ☐Asian ☐Native American ☐Alaskan Native ☐African American ☐Native Hawaiian ☐Pacific Islander ☐More than one race ☐Other:		Patient Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated ☐Domestic partner
Employment Status: ☐Employed Full-time ☐Unemployed ☐Employed Part-time ☐Retired	Employer Name:	Do you have an Advance Directive, POLST, Living Will, or Power of Attorney? ☐No ☐Yes, type:	

Communication Preferences

Phone: ☐Home ☐Cell ( ) -	Email Address:	
Preferred Communication Method: ☐MyChart ☐Text Message ☐Phone Call ☐Email ☐Other:		
Preferred Emergency Contact Name:	Relationship to Patient:	Emergency Phone Number: ( ) -

Responsible Party Information

Relationship to Patient: ☐Self (skip ahead) ☐Other:	Responsible Party Name:	Resp. Party Social Security Number: ___ - ___ - ____
Resp. Party Phone Number: ( ) -	Mailing Address: City: State: Zip: ☐Same as above	
Are you self-pay / uninsured? ☐No ☐Yes (skip to next page)		
Primary Insurance Company:	Policy/Member ID Number:	Policy Group Number:
Policy Holder Name: ☐Same as above	Policy Holder DOB: ☐Same as above	Policy Holder Social Security Number: ☐Same as above
Secondary Insurance Company:	Policy/Member ID Number:	Policy Group Number:
Policy Holder Name: ☐Same as above	Policy Holder DOB: ☐Same as above	Policy Holder Social Security Number: ☐Same as above

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Health History – Adult

Patient Name:_____ Date of Birth:_____ Today's Date:_____

Current Doctors / Providers / Specialists			
Are you transferring from out of state? ☐No ☐Yes, I am transferring from (city, state):			
Provider Type	Provider and Facility Name	Provider Type	Provider and Facility Name
Primary Doctor		Orthopedic Doctor (Bone/Muscle)	
Cardiologist (Heart)		Otolaryngologist (Ear/Nose/Throat)	
Dermatologist (Skin)		Pain Management	
Endocrinologist (Hormone)		Physical Therapy	
Gastroenterologist (Stomach)		Psychiatrist/Counselor	
Nephrologist (Kidney)		Pulmonologist (Lung)	
Neurologist (Nervous System)		Rheumatologist (Autoimmune)	
OB/GYN (Women's Health)		Social Worker/Case Worker	
Oncologist/Hematologist (Cancer)		Urologist (Kidney/Bladder)	

Current Medications:

List all prescriptions, over the counter, and any other medications that you currently take.
Please include any herbal or nutritional supplements, inhalers, eye drops, ointments, etc.

Preferred Pharmacy and Location:

Medication	Dose	Frequency
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:

Allergy Information

☐No Known Allergies ☐Medications ☐Tape/Adhesive (band-aids) ☐Latex ☐Food ingredient (gluten, lactose, etc.)

Allergen	Reaction	Allergen	Reaction

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Surgical History			
Operation/Procedure (bilateral, left, right, etc.)	Date	Reason	Hospital/Facility
(c-section, hysterectomy, tubal ligation, etc.)			

Current Medical Concerns (not past history): List your current complaints, conditions, and concerns	
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term

Past Medical History (not current issues)			
☐ Abuse (child, adult)	☐ Blood Clots	☐ Gall Stones	☐ Liver Problems
☐ Abnormal Heart Rhythm	☐ Breast Lump	☐ GERD	☐ Lung Disease
☐ Abnormal Pap Smear	☐ Cancer (specify)	☐ Glaucoma	☐ Mental Illness
☐ HIV/AIDS	☐ Cataracts	☐ Headaches	☐ Multiple Sclerosis
☐ Alcoholism	☐ Chronic Bronchitis	☐ Heart Disease	☐ Pacemaker
☐ Anemia	☐ Crohn's Disease	☐ Hepatitis	☐ Pneumonia
☐ Anorexia/Bulimia	☐ Colon Polyp	☐ Hernia	☐ Sleep Apnea
☐ Asthma	☐ COPD/Emphysema	☐ Herpes	☐ STD/STI
☐ Atrial Fibrillation	☐ Coronary Artery	☐ High Blood Pressure	☐ Stomach Ulcers
☐ Bladder Problems	☐ Depression	☐ High Cholesterol	☐ Stroke
☐ Blood Transfusion	☐ Diabetes	☐ Irregular Periods	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Epilepsy/Seizures	☐ Kidney Problems	☐ Tuberculosis

Preventive History					
Screening	Result	Date	Screening	Result	Date
Colonoscopy	☐Normal ☐Abnormal		Pap Smear	☐Normal ☐Abnormal	
Cologuard	☐Normal ☐Abnormal		Influenza Vaccine	☐ Decline Vaccine	
Fecal Occult Stool Test	☐Normal ☐Abnormal		COVID-19 Vaccine	☐ Decline Vaccine	
DEXA/Bone Density Scan	☐Normal ☐Abnormal		Pneumonia Vaccine	☐ Decline Vaccine	
Mammogram	☐Normal ☐Abnormal		Shingles Vaccine	☐ Decline Vaccine	

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Family Medical History:

Mark any family member who has experienced any of the following conditions

Condition	Mother	Father	Sister(s)	Brother(s)	Child(ren)	Grandmother	Grandfather
Arthritis	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Cancer (specify)	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Depression	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Diabetes	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Heart Disease	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
High Blood Press.	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Kidney Disease	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Stroke/TIA	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Substance Abuse	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Other:	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal

Social History

Exercise Routine:	☐Yoga ☐Walking ☐Other:	Days per Week:	Minutes of Exercise:
Tobacco Use:	☐Cigarettes ☐Smokeless Tobacco (chew, pouch, etc.) ☐Other:		Packs per Day:
Frequency:	☐Never ☐Daily ☐Some Days ☐Quit	Usage Dates: From _____	to _____
Vape Use:	☐Nicotine ☐THC ☐CBD ☐Other:		Cartridges per Day:
Frequency:	☐Never ☐Daily ☐Some Days ☐Quit	Usage Dates: From _____	to _____
Substance Use:	☐Marijuana ☐Amphetamines ☐Narcotics ☐Heroin ☐Other:		
Frequency:	☐Never ☐Not Currently ☐Recovering Addict ☐ I Use # _____ Times per Week		
Alcohol Use:	☐Wine ☐Beer ☐Liquor ☐Other:	Num of Drinks per Sitting: ☐1-2 ☐3-4 ☐5-6 ☐6+	
Frequency:	☐Never ☐2-4 Times per Month ☐2-3 Times per Week ☐4+ Times per Week ☐Alcoholic		
Sexual Activity:	Are you sexually active? ☐Yes ☐No	Partner(s): ☐Male ☐Female ☐Other:	
Birth Control:	☐None ☐Condom ☐Pill ☐Patch ☐I.U.D. ☐Surgical ☐Injection ☐Other:		

Women's Health History

Number of Pregnancies:	Number of Live Births:	Number of Miscarriages/Abortions:
Have you had a Mammogram Within the last 10 Months? ☐Yes ☐No		Result of Mammogram: ☐Normal ☐Abnormal
Are your Periods Regular each month? ☐Yes ☐No	Do you have Abnormal Bleeding? ☐Yes ☐No	