

**NEW APPOINTMENT REGISTRATION SHEET
FOR JOHN REGAN, M.D**

Date: _____

Patient Name: _____

Home Street Address: _____

City, State, Zip: _____

Daytime Phone: () _____ Evening Phone: () _____

Email Address: _____ Fax #: () _____

Date of Birth: ___ / ___ / ___ Sex: Male Female Social Security#: _____

Marital Status: Married Single Widowed Divorced

Ethnic Group: Caucasian Black Asian Hispanic Native American Other: _____

Occupation: _____ How did you hear about Dr. Regan? _____

Insurance

Primary Insurance: _____ PPO POS

Insurance address (including city, state & zip) _____

Insurance Phone: () _____ Policyholder: _____

Certificate/ID#: _____ Group #: _____

Secondary Insurance: _____ PPO POS

Insurance address (including city, state & zip) _____

Insurance Phone: () _____ Policyholder: _____

Certificate/ID#: _____ Group #: _____

Workers Compensation

Insurance Company: _____

Insurance address (including city, state & zip) _____

Adjustor Name: _____

Adjustor Phone (including extension): () _____ Ext. _____

Adjustor Fax: () _____

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Nurse Case Manager Name (if applicable): _____

Nurse Case Manager Phone (if applicable): () _____

Claim Number: _____ Date of Injury: _____

Employer: _____ WCAB Number: _____

Patient History

1. When did symptoms first start? _____

2. Please describe your symptoms (include the type of pain and the body part affected): _____

3. Does a position and/or medication relieve your pain? _____

4. Do you have any pain, numbness, tingling or weakness in your arms or legs? Please describe: _____

5. Are you presently working? Full Time Part time Disable Retired

6. Please list all testing (including x-rays, lab tests, EMG, MRI & CT scans, myelogram, physical therapy, etc) you have had done and the results: _____

7. Please list previous treatments given or recommended: _____

8. Are you currently receiving treatment for any other medical condition? _____

9. Medications: Please List **ALL** medications you are currently taking and the daily dosage:

Medication	Dosage	Medication	Dosage
1.		4.	
2.		5.	
3.		6.	

Please list any allergies: _____

10. Family Medical History:

Is there a history of spinal problems in your family? Yes No

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If yes, please describe: _____

Is there a family history of other medical problems? Please describe: _____

11. Social History:

Age: _____ Height: _____ Weight: _____ lbs.

Marital Status: _____ Children: _____

Do you smoke? _____ If so, how much? _____

Alcohol intake? _____ If so, how much? _____

12. Describe usual physical activity/exercise:

Type	Frequency	Type	Frequency
1.		4.	
2.		5.	
3.		6.	