Arbor Lane Medical Group

REGISTRATION FORM

PLEASE PRINT CLEARLY

Today's date:	Form Completed by

PATIENT INFORMATION

Last name:	First:	Middle:	Marital status (circle one) Single / Married / Divorced / Sep / Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Country of birth:	Referred By :

INS PHYSICAL HEALTH SCREENING QUESTIONS

Do you have any health problems?
❑ Yes
❑ No

Are you currently taking any medications?
❑ Yes
❑ No

Have you ever had a Positive TB skin test?
❑ Yes
❑ No

Have you ever had Chicken Pox?
❑Yes
❑ No

Any history of Drug abuse/ Addiction?
❑Yes
❑ No

Have you ever been treated for TB?
❑ Yes
❑ No

Any history of mental health disorder?
❑ Yes
❑ No

Any history of Sexually Transmitted disease?
❑ Yes
❑ No

I693 FEES

Physical Examination with blood test for quantiferon, Syphilis and Gonorrhea – **$300**

Additional Vaccines

MMR-$130 **Varicella-$200** **Tetanus-$40.00** **Influenza-$25.00** **Hepatitis B- $85.00**
Pneumovax $150

Patient
Signature____Date:________________