NEW CLIENT REGISTRATION

Dx Code: ______________________
Office Use Only

Tom F. Semper, M.D.
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(206) 329-5255, Ext. 313

Today's Date: ____________________________

Name: ____ Age: ______________ Sex: ____________

Address: ____

City, State, Zip: ____ Date of Birth: ____________________________

Home Phone: ______________________________ May I Call This Number? Y N Leave a Message? Y N

Cell Phone: ________________________________ May I Call This Number? Y N Leave a Message? Y N

Person Responsible for Bill: ______________________________________ Relationship: ____________________________

Address: ____ Phone: ________________________________

EMPLOYER INFORMATION

Employer: ____ Occupation: ____________________________

Address: ____

Work Phone: ______________________________ May I Call This Number? Y N Leave a Message? Y N

INSURANCE INFORMATION

Name of Insured: ______________________________ Social Security #: __________________________ DOB: ___________

Primary Insurance Company: ____

Address: ____ Phone: ________________________________

Subscriber/ID #: ____ Group #: ______________________________

Name of Insured: ______________________________ Social Security #: __________________________ DOB: ___________

Secondary Insurance Company: ____

Address: ____ Phone: ________________________________

Subscriber/ID #: ____ Group #: ______________________________

MEDICAL & REFERRAL INFORMATION

Name of Physician: ______________________ Phone: ______________

Name of Therapist/Counselor: ______________________ Phone: ______________

By Whom Were You Referred? ______________________ Relationship: ______________

HOUSEHOLD INFORMATION

Spouse/Partner Name: ______________________

Employer: ______________________ Work Phone: ______________

Others in Home:	Gender:	Age:	Relationship:

EMERGENCY CONTACT

If Emergency, Contact: ______________________ Relationship: ______________

Address: ____

Home Phone: ______________________ Work Phone: ______________

Legal Next of Kin: ______________________ Relationship: ______________

Address: ____

Home Phone: ______________________ Work Phone: ______________

FAMILY & MEDICAL HISTORY

	Living?	Age?	Illnesses/Cause of Death
Father:	Y N	_____	
Mother:	Y N	_____	
Brother / Sister:	Y N	_____	
Brother / Sister:	Y N	_____	

	Living?	Age?	Illnesses/Cause of Death
Son / Daughter:	Y N	_____	____
Son / Daughter:	Y N	_____	____
Partner (Male / Female):	Y N	_____	____

Have you ever had or do you currently have any of the following:

Head Injury with a Loss of Consciousness…………... Y/N

Seizure(s)………………………………………………………………………………………….……………... Y/N

Memory Lapses……………………………………………………………………..Y/N

Neuroleptic Malignant Syndrome (NMS)...Y/N

Heart Attack or Heart Problems………………………………………………………….....……………………. Y/N

High Blood Pressure………………………………………………………………………………….……………Y/N

Toxic Reaction to Medications or Drugs…………………………..………………………………….…………… Y/N

Diabetes………………………...Y/N

Asthma……………………………………………………………………………………………………….…. Y/N

Allergies to Medication(s)……….…………………………..…………………………………………………... Y/N

Thyroid, Parathyroid, or Adrenal Problems……………………………………...……………………….………. Y/N

Sexually Transmitted Diseases/HIV….…………………………………………………………………………... Y/N

Constipation/Bowel Obstruction……………………………………………………………………….…..……. Y/N

Difficulty Urinating…………………………………………………………………………………………….....Y/N

Glaucoma…………………………………………………………………………………….………………… Y/N

Other Medical Problems…………………………………………………………………………………………... Y/N

(Please Explain) ____

Are You Currently Taking Any Medications? Y N (Please List) __________________________________

____

Are You Pregnant? Y / N Don't Know Last Menstrual Period ____________

I HAVE READ THE OFFICE POLICY AND ACCEPT ITS CONTENTS

____ ________________________________

Signature Date