Satori Wellness
Karen Hoskins MSN/FNP-PC Family Nurse Practitioner
1100-C N.E. 7th Street Grants Pass, OR 97526
541-476-7000

Patient Registration Form

NAME: _____
(LAST) (FIRST) (MIDDLE) (TELEPHONE NUMBER)

STREET ADDRESS: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS: _____

GenderIdentity_____SexualOrientation_____DOB:_____/_____/_____SS#:_____

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐OTHER_____ HEIGHT _____ WEIGHT_____

EMPLOYMENT STATUS: ☐ ☐EMPLOYED ☐ ☐NOT EMPLOYED ☐ ☐FULL TIME STUDENT
☐ ☐PART TIME STUDENT ☐ ☐RETIRED
EMPLOYER: _____ PHONE NUMBER: _____

ADDRESS: _____

Whom may we thank for referring you? _____

May we leave a message on your answering machine to confirm your appointment? _____

Emergency Contact: _____ **Phone Number:** _____

RESPONSIBLE PARTY: Please fill out the information below (Check One):
☐PARENT ☐SPOUSE ☐OTHER RESPONSIBLE PARTY

_____
(LAST) (FIRST) (MIDDLE) (TELEPHONE NUMBER)

_____
(ADRESS) (CITY) (STATE) (ZIP CODE)

RELATIONSHIP TO PATIENT: _____ SS# _____ DOB: _____

EMPLOYER: _____ TELEPHONE: _____

PRIMARY INSURANCE: _____ ID#: _____

SECONDARY INSURANCE: _____ ID#: _____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Karen Hoskins, MSN/FNP-PC to provide my insurance companies with all information necessary to process insurance claims and assign payments to Karen Hoskins, MSN/FNP-PC all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. If it becomes necessary to effect collections for any amount owed, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

_____ _____

PATIENT OR GUARANTOR SIGNATURE DATE

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Patient History

Name:_____ Birthdate:_____Place of Birth:_____

Reason for visit:

Current Health Problems:

Other Medical Providers: (Please list provider and condition under treatment)

Past Medical History: (Diagnoses, Major illnesses, Hospitalizations)

Past Surgical History: (Procedures and Date)

Family History:

Mother: Living? Y N; age or age at death___ ;Illnesses:
Maternal Grandmother: Living? Y N age or age at death ___; Illnesses:
Maternal Grandfather: Living: Y N age or age at death ____ ;Illnesses:

Father: Living? Y N; age or age at death ____ Illnesses:
Paternal Grandmother: Living? Y N; age or age at death ____ Illnesses:
Paternal Grandfather: Living? Y N; age or age at death____ Illnesses:

Sibling: Please indicate ages or ages at death and illnesses of brothers and sisters:

Children: Please indicate ages or ages at death and illnesses:

Grandchildren: Please indicate ages or ages at death and illnesses:

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Social History:

Occupation:_____Education:_____Pets:_____

Hobbies:_____ Marital Status: M D S W Health of Partner:_____

How would you describe your health? (circle one) Excellent Good Fair Poor

Tobacco: Current? Y N; If former, date quit_____ Number of packs or cans per day for how many years?_____

Alcohol: Current? Y N; If former, date quit_____ If current, number of drinks per day_____

Caffeine: Number of caffeinated drinks per day_____

Recreational drugs: Current? Y N; What drugs?_____ How often?_____ If former, date quit_____

Are you on a special diet?_____ If so, what type of diet?_____

Do you exercise? Y N If so, what type?_____ How long ?_____How many days per week?_____

How many hours of sleep do you get most nights?_____

Who lives in your home with you?_____

Type of Heat in Home_____ Type of water in home: (circle one) well city

Health Maintenance: (please indicate how long ago for the following)

Last physical exam:_____ By whom and where:_____

Last labs:_____ Results?_____

Last Colonoscopy:_____ Results?_____

Last DEXA (bone density) _____ Results?_____

Women:

Age of 1st menses:_____ Last Menses:_____ Birth control_____

# of Pregnancies_____ # of Live Births_____

Last PAP_____ Results? _____ Last Mammo_____ Results? _____

Men:

Last PSA:_____ Results?_____

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Medications

What pharmacy do you use? _____

Allergies: (please include medications, foods, latex, dye, etc)

Please list all medications (prescribed and over-the-counter). Please bring your medications with you to every visit.

Medication	Dose	Frequency	Reason Why