ima | Healthcare
Internal Medicine Associates

4450 31st Ave S • Suite 102
MedPark Building • Fargo, ND 58104
701.280.2033 • Fax: 701.232.5578

New Patient Registration Form

Patient Information (Please Fill In Completely)

Name of Patient: _____ _____ _____ Date of Birth:_____
(Last) (First) (MI)

Address: _____ Apt/Suite # (if applicable): _____

City: _____ State: _____ Zip Code: _____

SSN: _____-_____-_____ Male Female

Phone: (Home) _____ (Cell) _____ (Work) _____

Email: _____

Marital Status: _____Single _____Married _____Divorced _____Widowed

Name of Primary Care Physician_____

Medical History (circle all that apply)

Arthritis: Osteoarthritis Rheumatoid Psoriatic

GI: Esophageal Reflux Gastric Ulcer Hemorrhoids Pancreatitis

Liver: Gall Stones Cirrhosis Hepatitis

Bowels: Colitis Diverticulosis Diverticulitis IBS Crohn's Disease Ulcerative Colitis

Blood: Anemia Coagulopathy HIV/AIDS DVT Cancer

Diabetes: Type 1 Type 2

ENT: Chronic Ear infections Allergies Chronic Sinusitis Runny Nose

Mouth/Throat: Gingivitis Chronic Cough Chronic Laryngitis Sleep Apnea

GU: Prostatitis Varicocele Incontinence Post-Menopausal Bleeding Abnormal Menstral Cycle

Heart: Heart Attack Angina Heart Murmur Cardiomyopathy Abnormal Rhythm Heart Failure
High Blood Pressure High Cholesterol

Lung: COPD Asthma Hx of Pneumonia Hx of Pulmonary Embolism

Kidney: Dialysis Kidney Disease

Musculoskeletal: Gout Lupus Osteoporosis Fibromyalgia Chronic Back Pain Chronic Neck Pain

Neurological: Alzheimer's Dementia Parkinson's Migraine Headaches Seizures Multiple Sclerosis
Neuropathy Stroke TIA's

Psychiatric: Depression Bipolar Disorder Anxiety Panic Disorder ADHD Insomnia Anorexia Bulimia

Skin: Acne Psoriasis Dermatitis Rash

Thyroid: Hypothyroidism Hyperthyroidism

Other: _____

_____**I have no significant Medical History**

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Social History:

Do you use tobacco? _____ Yes _____No Do you Drink Alcohol? _____Yes _____No

Do you use drugs? _____Yes _____No

Have you had any surgeries? _____Yes _____No

Explain:_____

Family Medical History:

Mother:_____

Father: _____

Siblings:_____

Current Medications: (name and dosage)

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:

_____

_____

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Insurance

(We will take a copy of your card)

Name: (if different) _____

Primary (Name of Insurance and ID): _____

Work Comp: _____

Important Information:

Please Read Carefully

1. I, the patient, and/or head of household do authorize any holder of medical information about me to release to my insurance providers any information needed to determine the benefits payable for related services.

2. I request that payment of authorized insurance or Medicare benefits be services furnished to me by this clinic.

3. I understand and agree that I will be responsible for the payment of any services not covered by payments from any insurance companies or other third parties.

I have received a copy of the HIPAA Notice of Privacy Practices

Signature of Patient: _____ Date: _____