Robert C. Raley, MD
Aline C. Zeringue, RN, ACNS-BC
Amanda Mishra, RN, ACNS-BC
Eileen M. Costa, APRN, FNP-C
Belinda Read, AGCNS-BC

PRIMARY CARE
KEEPING AUSTIN HEALTHY

REGISTRATION INFORMATION

DEMOGRAPHIC INFORMATION

Date

Last Name First Name Preferred Name

DOB Gender at birth

Primary Phone Number Alternate Phone Number

Primary Email Address

Mailing Address

Emergency Contact Name Emergency Contact Phone

Emergency Contact Email Emergency Contact Relation

INSURANCE POLICY INFORMATION

Patients are required to present proof of insurance coverage PRIOR to services, otherwise patient will be responsible for full payment of services at time of visit

Primary Insurance Co.: ID#: Group#:
Subscriber's Name: Date of Birth: SS#:

Secondary Insurance Co.: ID# Group#:

MEDICAL HISTORY

Please list any drug allergies:

Please note if you have ever been diagnosed with the following:

High Blood Pressure ☐ Diabetes ☐ High Cholesterol ☐

Heart Rhythm Problems☐ Heart Failure ☐ Asthma ☐

COPD ☐ Thyroid Problems ☐ Sleep Apnea ☐

Sleep Disorder Cancer (please list type) ☐

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Please list any other medical diagnoses that have been made in the past:

Please list all surgeries you have had in the past:

Please list any specialists you see regularly, or who may prescribe medication to you:

Please list all prescription medications (you may also attach a list):

Please check if you have had the following, and enter the approximate date:

☐ Colonscopy

☐ Mammogram

☐ Bone Density

☐ Papsmear

☐ Lung Cancer Screening

☐ Echocardiogram

☐ Stress Test

☐ Heart Saver/Heart Calcium Scan

Please check if you have had the following, and enter the approximate date:

☐ COVID vaccine

☐ Tetanus/Diptheria/Pertussis vaccine

☐ Shingles vaccine

☐ Pneumonia vaccine

☐ Gardasil (HPV) vaccine

List dates and location of any recent ER visits or hospitalizations:

When was your last complete physical exam with blood work:

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Females Only:

How many times (if ever) have you been pregnant?

How many live babies were born?

Are you on birth control? What type?

When was your last menstrual period?

FAMILY HISTORY

List any family members who have had the following:

Heart Attacks

Strokes

Cancer – please list type

Diabetes

Other

SOCIAL HISTORY

Do you currently smoke?☐ If so, how many cigs/week? When did you start smoking?

If you previously smoked, how many years did you smoke? When did you quit?

Do you currently drink? ☐ If so, how many drinks/week?

Do you currently exercise? ☐ If so, how many days a week?

Are you: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Occupation/Employer:

How did you find our office:

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