New Patient Registration

KNOX CLINIC
Your Mid Coast Health Net

Full Name _____ Date of Birth ____/__/____

Legal Name
(if different) _____ Phone Number _____

Gender ☐ Woman ☐ Man ☐ Transgender ☐ Nonbinary ☐ _____ ☐ Do not wish to disclose
(select all that apply)

Pronouns ☐ she/her ☐ he/him ☐ they/them ☐ _____ ☐ Do not wish to disclose
(select all that apply)

Sex assigned at birth ☐ Male ☐ Female Email _____

Mailing Address _____
Street # Street name Apt # City State Zip code

Emergency Contact _____
Name Contact Relationship to you

Demographics:

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered

Sexual Orientation ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ I don't know ☐ _____ ☐ Do not wish to disclose

Race ☐ White ☐ Black ☐ Asian ☐ Indigenous American ☐ Hawaiian/ Pacific Islander ☐ _____ ☐ Do not wish to disclose
(select all that apply)

Are you Hispanic? ☐ Yes ☐ No Country of origin: _____

Primary language _____ Do you need an interpreter? ☐ Yes ☐ No

How did you hear about the Knox Clinic? ☐ Friend/Family ☐ Google ☐ Social Media ☐ Other: _____ ☐ Flyer/Brochure

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☐ I give my permission to obtain medical history from my pharmacy, health plans, and other healthcare providers

☐ I do not give my permission at this time

_____ ____/__/____
Patient Signature Date

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Are you a veteran? ☐ Yes ☐ No ☐ Do not wish to disclose

Do you have a stable place to live? ☐ Yes ☐ No ☐ Do not wish to disclose

Do you work in Agriculture? ☐ Yes ☐ No ☐ Do not wish to disclose

Please list medication allergies and your reaction to them (e.g., nausea, hives, swelling, etc).

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Have you been hospitalized for illness or injury? ☐ Yes ☐ No

If yes, when? _____

Have you been to the emergency department in the last 3 months? ☐ Yes ☐ No

If yes, when? _____

Previous primary care provider (name and office if known) _____

Reason for your visit: _____

Preferred Pharmacy _____

Insurance Information:

Insurance Company: _____

Subscriber Legal Name: _____

Subscriber Number: _____

Group Number: _____

☐ I do not have insurance and need an application for the sliding scale fee

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Income information:

Family Size _____ ☐ Do not wish to disclose

Income: _____ ☐ Do not wish to disclose

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Please note any medical conditions you currently have or have had previously

- ☐ Seizures/Epilepsy
- ☐ Digestive issues *(indigestion, heartburn, diarrhea, constipation, etc.)*
- ☐ Chest pain and/or stents in the last 6 months
- ☐ Heart attack
- ☐ Artificial Heart valve/ repaired heart defect (PFO)
- ☐ Pacemaker or implantable defibrillator
- ☐ High or low blood pressure
- ☐ Stroke/TIA and/or Blood clot(s)/DVT
- ☐ Taking Aspirin or other blood thinners regularly
- ☐ Frequently swollen feet, ankles, etc.
- ☐ Anemia
- ☐ Fainting/Light headedness
- ☐ Dizziness/Vertigo
- ☐ COPD/Emphysema/Chronic Bronchitis/Asthma
- ☐ Type 1 or Type 2 Diabetes
- ☐ Depression/ Seasonal Depression
- ☐ Anxiety
- ☐ Sexually Transmitted Infection(s) _____
- ☐ Hepatitis (specify type) _____
- ☐ Gallbladder disease/stones/removed
- ☐ Lyme or other tick-borne diseases
- ☐ Viral infection (type) _____
- ☐ Hives, skin rash, and/or eczema
- ☐ Insomnia and/or Chronic Fatigue
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ ADD/ADHD
- ☐ Rheumatoid arthritis and/or Lupus
- ☐ Osteoporosis/Osteopenia
- ☐ Artificial Joints (Knee, hip, etc.)
- ☐ Head, Neck and/or Back Injuries
- ☐ Glaucoma/Macular degeneration/Cataracts
- ☐ Pain/burning when urinating
- ☐ Frequent urination - day and/or nighttime
- ☐ Kidney Stones/Solitary kidney
- ☐ Frequent Migraines
- ☐ Crohn's disease/Colitis/IBS
- ☐ Hemorrhoids and/or pain with bowel movement
- ☐ Painful Intercourse/Pain in genitals
- ☐ Tested positive for COVID-19 (date) _____
- ☐ Cyst/tumor/abnormal growth (where)_____
- ☐ Cancer (type) _____
- ☐ Radiation/Chemo/Immunosuppressive therapy
- ☐ Seasonal Allergies/Hay fever
- ☐ OTHER not listed: _____

_____

FAMILY MEDICAL HISTORY (leave blank if unknown:

Mother _____

Mother's Parents _____

Father _____

Father's Parents _____