GULF STATES HEMOPHILIA AND THROMBOPHILIA CENTER
NEW PATIENT REGISTRATION FORM

NAME Last: _____ First: _____ Middle: _____ **DOB:** _____/_____/_____

Appt. DATE: _____/_____/_____ **Time** _____ **IDX No.** _____

PATIENT INFORMATION _____ **New** _____ **Established** _____ **Labs only** **GENDER:** _____ Male _____ Female

PREFERRED LANGUAGE: _____English _____ Spanish _____ Other *specify*_____

ETHNICITY: _____ Hispanic, Latino/a or Spanish origin _____ Not Hispanic, Latino/a or Spanish origin _____ Unknown

RACE: _____ White _____ Black/African American _____ Asian _____ Native Hawaiian/ Other Pacific Islander

_____ American Indian/Alaska Native _____ Unknown

ADDRESS: _____ **APT#**_____

CITY: _____ **STATE:** _____ **ZIP:** _____ **COUNTY:** _____

PHONE NUMBER: _____ **CELL NUMBER:** _____

EMAIL ADDRESS: _____

PATIENT EMPLOYER INFORMATION If ***patient*** is employed, please complete

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

WORK NUMBER : _____

PARENT/SPOUSE INFORMATION: _____ **MOTHER** _____ **FATHER** _____ **SPOUSE**

LAST NAME _____ **FIRST NAME:** _____ **DOB:** _____/_____/_____

ADDRESS *if different from patient's:* _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: _____ **CELL NUMBER:** _____

CURRENTLY EMPLOYED: _____ **EMPLOYER:** _____ **OCCUPATION:** _____

EMPLOYER'S ADDRESS: _____ **CITY:** _____ **STATE** _____ **ZIP** _____

WORK PHONE NUMBER: _____

IS PATIENT COVERED ON YOUR INSURANCE? ____ **Yes** ____ **No** **DATE INSURANCE STARTS** _____

PARENT/SPOUSE INFORMATION: _____ **MOTHER** _____ **FATHER** _____ **SPOUSE**

LAST NAME _____ **FIRST NAME:** _____ **DOB:** _____/_____/_____

ADDRESS *if different from patient's:* _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: _____ **CELL NUMBER:** _____

CURRENTLY EMPLOYED: _____ **EMPLOYER:** _____ **OCCUPATION:** _____

EMPLOYER'S ADDRESS: _____ **CITY:** _____ **STATE** _____ **ZIP** _____

WORK PHONE NUMBER: _____

IS PATIENT COVERED ON YOUR INSURANCE? ____ **Yes** ____ **No** **DATE INSURANCE STARTS** _____

GULF STATES HEMOPHILIA AND THROMBOPHILIA CENTER
NEW PATIENT REGISTRATION FORM

NAME Last: _____ First: _____ Middle: _____ **DOB:** _____/_____/_____

EMERGENCY CONTACT

FULL NAME: _____ **RELATIONSHIP TO PATIENT:** _____

PHONE NUMBER: _____

PHYSICIAN INFORMATION

NAME OF PRIMARY CARE PHYSICIAN (PCP): _____ _____

PHONE NUMBER: _____ **FAX NUMBER:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

Check if you do not have a PCP _____

NAME OF REFERRING PHYSICIAN ***If Different from PCP*** _____

PHONE NUMBER: _____ **FAX NUMBER:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

MEDICAL INFORMATION

REASON FOR VISIT _____

DOES PATIENT HAVE ANY ALLERGIES TO MEDICATION? ____ Yes ____ No

LIST: _____

HAS PATIENT EVER BEEN DIAGNOSED WITH A BLEEDING DISORDER? ____ Yes ____ No

DIAGNOSIS: _____**DATE OF DIAGNOSIS:** _____/_____/_____

DOES ANYONE IN YOUR FAMILY HAVE A BLEEDING DISORDER? ____ Yes ____ No

IS PATIENT CURRENTLY ON HOME INFUSION THERAPY? ____ Yes ____ No

HAS PATIENT EVER BEEN DIAGNOSED WITH AN INHIBITOR? ____ Yes ____ No

FAMILY RELATIONSHIPS

Hemophilia and Thrombophilia can be inherited through families. It is important for us to keep track of our patients' family relationships. Please help us by completing the information below. Any information is confidential and will not be shared with anyone other than clinic personnel.

Relatives of yours who are also our patients at this clinic:

Name	**Relationship to you**
_____	_____
_____	_____
_____	_____

Notes