Center for Family Practice

8 Century Hill Drive Latham, NY 12110
tel: 518.783.7173 fax: 518.783.5426

Gerald J. Hausler, D.O. Theodore Hausler, D.O. Jessica Hausler, P.A. Amy Lane, N.P.

PATIENT INFORMATION — please write information about the patient here

Name: _____ Birthdate: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Email: _____

Marital Status: _____ Sex: ❑ Male ❑ Female

Employer: _____ Employers Address: _____

Work Phone: _____ Occupation: _____

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Employed

In Case of an Emergency — who should we contact? List someone living at a residence other than listed below:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Other: _____

RESPONSIBLE PARTY INFORMATION — please complete the information below if the person responsible for paying the bill is not the PATIENT or the POLICYHOLDER

Responsible party is: ❑ Patient ❑ Primary Policyholder ❑ Secondary Policyholder

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____

Relationship to Patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Other: _____

Employers Name: _____ Employers Address: _____

Work Phone: _____ Sex: ❑ Male ❑ Female

INSURANCE INFORMATION — please write information about the policyholder here

Primary Ins. Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurer's ID #: _____ Group Plan #: _____

Secondary Ins. Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurer's ID #: _____ Group Plan #: _____

Consent For Treatment: Authorization of treatment for myself and my children. Emergency treatment in the event children are brought here by any person other than a parent.

Print Name: _____ Signature: _____

REGISTRATION AND HISTORY RECORD

Current medicines— List medicines, birth control pills, or vitamins you take with or without a prescription:

Hospitalizations— List serious illnesses and injures or operations, approximate year, and name of hospital. EXCLUDE normal pregnancies:

Drug/Other Allergies— List those to which you are allergic:

Immunizations— Check those that you have had:

❑ Pneumonia ❑ Tetanus ❑ Polio ❑ Rubella ❑ Flu ❑ Others:

Pregnancy History— Enter the number of:

Times pregnant _____ Premature births _____ Miscarriages ____ Abortions _____

Live births _____ Living children _____

Your Work/Exposure History

Are you working now? ❑ Yes ❑ No, I am out of work ❑ No, I'm retired

❑ I've never been employed

Starting with our most recent job, what type of work have you done?

Type of work:	From:	To:

Your Family's Health

First Name/relation:	Yr. of birth:	Health is: Good	Health is: Poor	Died at Age:	Cause of death:
		❑	❑		
		❑	❑		
		❑	❑		
		❑	❑		
		❑	❑		
		❑	❑		
		❑	❑		
		❑	❑		
		❑	❑		
		❑	❑		

ILLNESSES

Indicate where you or members of your family have had the following illnesses or problems:

You	Your Family	
❑	❑	Alcoholism
❑	❑	Anemia
❑	❑	Asthma
❑	❑	Cancer, tumor
❑	❑	Diabetes
❑	❑	Drug abuse
❑	❑	Depression
❑	❑	Eczema, hives, rashes
❑	❑	Epilepsy
❑	❑	Eye problems
❑	❑	Glaucoma
❑	❑	Heart disease
❑	❑	High blood pressure
❑	❑	Kidney/bladder problems
❑	❑	Liver disease, hepatitis, yellow jaundice
❑	❑	Lung disease, tuberculosis
❑	❑	Mumps, measles, chicken pox
❑	❑	Nervous breakdown/ mental illness
❑	❑	Phlebitis
❑	❑	Rheumatic fever
❑	❑	Rubella, German measles
❑	❑	Stroke
❑	❑	Suicide attempt
❑	❑	Thyroid disease
❑	❑	Ulcer in stomach /duodenum
❑	❑	Uncontrolled bleeding
❑	❑	Venereal disease
❑	❑	Other illnesses: