

**TED L. EDWARDS, JR., M.D.**  
 4201 Bee Caves Road, Suite B-112  
 Austin, Texas 78748

**PATIENT REGISTRATION FORM**

DATE: \_\_\_\_\_

Please Print Legibly

**PATIENT INFORMATION**

LAST NAME		FIRST NAME		M.I.
ADDRESS			APT/UNIT	
CITY		STATE	ZIP	
HOME PHONE ( )	WORK PHONE ( )	OTHER ( )		
DATE OF BIRTH (MM/DD/YYYY)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	STATE
EMPLOYER NAME AND ADDRESS				
E-MAIL ADDRESS			SPOUSE/SIGNIFICANT OTHER (NAME)	
NEXT OF KIN	RELATIONSHIP	PHONE ( )		

**IN CASE OF EMERGENCY, PLEASE CONTACT**

CONTACT # 1	RELATIONSHIP	DAY PHONE ( )
		NIGHT PHONE ( )
CONTACT # 2	RELATIONSHIP	DAY PHONE ( )
		NIGHT PHONE ( )

**PAYMENT INFORMATION**

HOW DO YOU PLAN TO PAY FOR YOUR VISIT TODAY? <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD	RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER
PRIMARY INSURANCE CARRIER	ID NO.    GROUP NO.
SECONDARY INSURANCE CARRIER	ID NO.    GROUP NO.

**CONTACT INFORMATION**

PRIMARY PHARMACY	PHONE ( )	FAX ( )
SECONDARY PHARMACY	PHONE ( )	FAX ( )

**MISCELLANEOUS**

WEIGHT	HEIGHT	HAIR COLOR	EYE COLOR	BLOOD TYPE
ORGAN DONOR <input type="checkbox"/> YES <input type="checkbox"/> NO	LIVING WILL <input type="checkbox"/> YES <input type="checkbox"/> NO	LANGUAGES (S) SPOKEN		
RELIGIOUS PREFERENCE	HIGHEST LEVEL OF EDUCATION			

**INSURED PARTY'S INFORMATION (if same as above do not complete)**

LAST NAME		FIRST NAME		M.I.
ADDRESS			APT/UNIT	
CITY		STATE	ZIP	
HOME PHONE ( )	WORK PHONE ( )	OTHER ( )		
SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	EMPLOYER		

### ADDITIONAL PHYSICIANS

Please list below all other physicians you are currently seeing for any reason.

Reason/Problem	Physician or Medical Facility	City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

### RELEASE OF MEDICAL RECORDS

If you wish for us to provide your records or information pertaining to your appointments, to someone other than yourself, please list name (s) below.

NAME: \_\_\_\_\_  
NAME: \_\_\_\_\_

### CONSENT

I understand I am responsible for the payment of all services rendered by Ted L. Edwards, Jr., M.D., P.A., at the time service is performed unless arrangements are made with the office manager. I may be subject to a \$ 50.00 minimum NO SHOW fee should I fail to give a 24-hour cancellation notice. By my signature, I consent to treatment.

I authorize the release of any medical records or other information necessary in order to process this claim with my insurance company and/ or attorney. This further authorizes payment be made directly to the physician.

To assure that my healthcare providers have comprehensive up-to-date medical records, I authorize Critical Connection, Inc. to release my medical records, including all future updates, to all my healthcare providers named above, unless otherwise noted below. Likewise, all providers named above, unless otherwise noted below, are authorized to release my medical record to Critical Connection, Inc. to accomplish that update.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Parent or Legal Guardian)

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

## CURRENT MEDICAL CONDITION

Please describe why you came to see the doctor.

\_\_\_\_\_ DATE PROBLEM BEGAN \_\_\_\_\_  
 \_\_\_\_\_ DATE PROBLEM BEGAN \_\_\_\_\_  
 \_\_\_\_\_ DATE PROBLEM BEGAN \_\_\_\_\_

## FOR WOMEN ONLY

I wish to have a nurse in the exam room when the doctor examines my chest. YES  NO  DOESN'T MATTER

### ALLERGIES

Yes/No	Reaction	Start Date
<input type="checkbox"/>	NONE	
<b>MEDICATION ALLERGIES</b>		
<input type="checkbox"/>	Aspirin	_____
<input type="checkbox"/>	Codeine	_____
<input type="checkbox"/>	Morphine	_____
<input type="checkbox"/>	Penicillin	_____
<input type="checkbox"/>	Sulfa	_____
<input type="checkbox"/>	X-Ray Dye	_____
<b>FOOD ALLERGIES</b>		
<input type="checkbox"/>	Eggs	_____
<input type="checkbox"/>	Peanuts	_____
<input type="checkbox"/>	Shellfish	_____
<b>ENVIRONMENTAL ALLERGIES</b>		
<input type="checkbox"/>	Dust	_____
<input type="checkbox"/>	Grass	_____
<input type="checkbox"/>	Molds	_____
<input type="checkbox"/>	Ragweed	_____
<input type="checkbox"/>	Animals	_____
<input type="checkbox"/>	Cedar	_____
<input type="checkbox"/>	Fire Ants	_____
<input type="checkbox"/>	Flying Insects	_____

OTHER \_\_\_\_\_  
 See attached for more

### MEDICATIONS

Name	Dosage	Frequency
<b>PRESCRIPTION MEDICATION</b>		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### OVER THE COUNTER MEDICATION

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### SUPPLEMENTS

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

See attached for more

### SURGERIES

Yes/No	Type	Year
<input type="checkbox"/>	Tonsils	_____
<input type="checkbox"/>	Appendix	_____
<input type="checkbox"/>	Gallbladder	_____
<input type="checkbox"/>	Stomach*	_____
<input type="checkbox"/>	Kidney*	_____
<input type="checkbox"/>	Colon*	_____
<input type="checkbox"/>	Thyroid	_____
<input type="checkbox"/>	Hernia	_____
<input type="checkbox"/>	Breast*	_____
<input type="checkbox"/>	Uterus	_____
<input type="checkbox"/>	Ovaries*	_____
<input type="checkbox"/>	Prostate	_____
<input type="checkbox"/>	Joint Replacement	_____
<input type="checkbox"/>	Amputation*	_____
<input type="checkbox"/>	Tubal Ligation	_____
<input type="checkbox"/>	Vasectomy	_____
<input type="checkbox"/>	C-Section	_____
<input type="checkbox"/>	Hysterectomy	_____
<input type="checkbox"/>	Hemorrhoidectomy	_____
<input type="checkbox"/>	Other	_____
<input type="checkbox"/>	Other	_____
<input type="checkbox"/>	See attached for more	

### GENERAL

Changes in appetite  
 Changes in thirst  
 Changes in weight  
 Changes in energy level

### HEAD

Headaches  
 Migraines  
 Tension  
 TMJ  
 Dental problems  
 Injury

### EYES

Visual difficulty  
 Double vision  
 See color halos  
 Contacts  
 Glasses  
 Cataracts  
 Glaucoma  
 Injury

### EARS

Hearing difficulty  
 Chronic ear infection  
 Tubes  
 Hearing aids  
 Ringing  
 Loss of balance  
 Injury

### NOSE

Polyps  
 Sinusitis  
 Allergies  
 Nosebleeds  
 Injury

### LUNGS

Tuberculosis  
 Pneumonia  
 Asthma  
 Emphysema  
 Pleurisy  
 Cough  
 Cough up blood  
 Shortness of breath  
 Chronic bronchitis  
 Cancer  
 Smoker  
 Secondhand smoke  
 Chest x-ray Date: \_\_\_\_\_

### HEART/CIRCULATORY

High blood pressure  
 Chest pain  
 Heart murmur  
 Heart disease  
 Abnormal EKG  
 Rapid heart beat  
 Heart attack  
 Varicose veins  
 Phlebitis  
 Blood transfusions  
 Bruise easily  
 Anemic  
 Pacemaker  
 Heart surgery  
 Swelling of ankles or feet

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

## GASTRO-INTESTINAL

- Yes/No
- Digestive problems
  - Heartburn
  - Ulcers
  - Nausea/vomiting
  - Diarrhea
  - Hemorrhoids
  - Bloody stools
  - Constipation
  - Black bowel movement
  - Gallbladder disease
  - Rectal bleeding
  - Anorexia/Bulimia
  - Colostomy

## GENITO-URINARY

- Chronic urinary tract infections
- Urinary problems
- Kidney stones
- Gonorrhea
- Syphilis
- Herpes
- Chlamydia
- Other: \_\_\_\_\_

## MUSCLE/BONE

- Painful/swollen joints
- Back pain
- Back injury
- Arthritis
- Disease of the muscle or joint
- Muscle spasms
- Bursitis
- Tendinitis
- Gout
- Carpal Tunnel Syndrome
- Injury, Type: \_\_\_\_\_

## LIVER

- Jaundice
- Hepatitis
- Cancer
- Cirrhosis

## BLOOD

- Anemic
- Clotting problems
- High blood sugars
- Low blood sugars
- Contact w/ blood products
- Transfusion(s)
- HIV+
- Hepatitis

## NEUROLOGICAL

- Yes/No
- Seizures/Convulsions
  - Parkinson's disease
  - Fainting spells
  - Stroke
  - Cerebral hemorrhages
  - Loss of consciousness
  - Paralysis
  - Cancer
  - Brain Tumor
  - Alzheimer's disease
  - Attention Deficit Disorder

## SKIN

- Cancer
- Psoriasis
- Eczema
- Dry skin
- Loss of pigment
- Moles
- Warts
- Rashes
- Bruising or bleeding
- Ulcers

## OTHER

- See attached for more

## GENDER RELATED/FEMALE

- \_\_\_\_\_ Number of pregnancies
- \_\_\_\_\_ Number of premature births
- \_\_\_\_\_ Number of live births
- Complications of pregnancy, Type: \_\_\_\_\_
- C-section
- Abortion
- Birth control pills
- Use estrogen/progesterone
- Tubal ligation
- Other birth control, Type: \_\_\_\_\_
- \_\_\_\_\_ Age menses started
- \_\_\_\_\_ Age menses stopped
- Abnormal periods
- PMS
- Endometriosis
- Hysterectomy, Type: \_\_\_\_\_
- Vaginal infections
- Vaginal discharge
- Vaginal dryness
- Cancer, Type: \_\_\_\_\_
- Hot flashes
- Night sweats
- Ovarian cysts
- Breast lumps/discharge
- Fibrocystic disease
- Self breast exams
- Pap Smear Date: \_\_\_\_\_
- Mammogram Date: \_\_\_\_\_

## GENDER RELATED/MALE

- Yes/No
- Penile discharge
  - Swelling of groin
  - Difficulty urinating
  - Epididymitis
  - Difficulty with erection
  - Impotence
  - Cancer, Type: \_\_\_\_\_
  - Vasectomy
  - Swelling of scrotum
  - Pain or lumps in testicles
  - Prostate disease

## LIFESTYLE

- Married  Widowed  Divorced  Single
- \_\_\_\_\_ Number of children living at home
- Ages: \_\_\_\_\_
- \_\_\_\_\_ Number of others living at home
- Type of work: \_\_\_\_\_
- Level of stress: \_\_\_\_\_
- Caffeine use: \_\_\_\_\_ per day
- Alcohol use: \_\_\_\_\_ per week
- Tobacco use: \_\_\_\_\_ per day
- Substance use: \_\_\_\_\_ per week
- Victim of abuse

## EXERCISE

- Type: \_\_\_\_\_
- Minutes and times per week \_\_\_\_\_

## HISTORY OF TRAUMA

- | Yes/No  | Date                           |
|---|--------------------------------|
| <input type="checkbox"/> <input type="checkbox"/> | Head: Concussion               |
| <input type="checkbox"/> <input type="checkbox"/> | Head: Laceration               |
| <input type="checkbox"/> <input type="checkbox"/> | Head: Closed Injury            |
| <input type="checkbox"/> <input type="checkbox"/> | Facial: Eye                    |
| <input type="checkbox"/> <input type="checkbox"/> | Facial: Ear                    |
| <input type="checkbox"/> <input type="checkbox"/> | Facial: Nose                   |
| <input type="checkbox"/> <input type="checkbox"/> | Facial: Jaw                    |
| <input type="checkbox"/> <input type="checkbox"/> | Neck: Fracture                 |
| <input type="checkbox"/> <input type="checkbox"/> | Neck: Injury                   |
| <input type="checkbox"/> <input type="checkbox"/> | Shoulder/Clavicle: Fracture    |
| <input type="checkbox"/> <input type="checkbox"/> | Shoulder/Clavicle: Dislocation |
| <input type="checkbox"/> <input type="checkbox"/> | Arm: Fracture                  |
| <input type="checkbox"/> <input type="checkbox"/> | Arm: Dislocation               |
| <input type="checkbox"/> <input type="checkbox"/> | Hand/Fingers: Fracture         |
| <input type="checkbox"/> <input type="checkbox"/> | Hand/Fingers: Dislocation      |
| <input type="checkbox"/> <input type="checkbox"/> | Torso: Rib Fracture            |
| <input type="checkbox"/> <input type="checkbox"/> | Torso: Chest Injury            |
| <input type="checkbox"/> <input type="checkbox"/> | Torso: Cardiac Trauma          |
| <input type="checkbox"/> <input type="checkbox"/> | Torso: Organ Trauma            |
| <input type="checkbox"/> <input type="checkbox"/> | Torso: Back Injury             |
| <input type="checkbox"/> <input type="checkbox"/> | Genitalia: Trauma              |
| <input type="checkbox"/> <input type="checkbox"/> | Leg: Fracture                  |
| <input type="checkbox"/> <input type="checkbox"/> | Leg: Amputation                |
| <input type="checkbox"/> <input type="checkbox"/> | Leg: Laceration                |
| <input type="checkbox"/> <input type="checkbox"/> | Leg: Dislocation               |
| <input type="checkbox"/> <input type="checkbox"/> | Foot/Ankle: Fracture           |
| <input type="checkbox"/> <input type="checkbox"/> | Foot/Ankle: Amputation         |

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

**MENTAL STATUS**  
 Yes/No

Nervous  
  Depressed  
  Trouble making decisions  
  Anxious or uneasy  
  Sexual problems  
  Bored  
  Thoughts of suicide  
  Need to talk  
  Panic or desperation  
  Recent changes in lifestyle  
  Other:  
 \_\_\_\_\_  
 \_\_\_\_\_

**IMMUNIZATIONS**  
 Yes/No Date of Last Immunization

Flu \_\_\_\_\_  
  Pneumonia \_\_\_\_\_  
  Rubeola \_\_\_\_\_  
  Rubella \_\_\_\_\_  
  Mumps \_\_\_\_\_  
  MMR (Measles/Mumps/Rubella) \_\_\_\_\_  
  TB Test \_\_\_\_\_  
  Polio \_\_\_\_\_  
  DPT (Diphtheria/Perussia/Tetanus) \_\_\_\_\_  
  DT (Diphtheria/Tetanus) \_\_\_\_\_  
  Hepatitis A \_\_\_\_\_  
  Hepatitis B \_\_\_\_\_  
  Other:  
 \_\_\_\_\_

**PROSTHESIS**  
 Yes/No

Artificial Joints  
  Dentures  
  Hearing Aid(s)  
  Pacemaker  
  Implants  
  Transplants  
  Other:  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY**

Please indicate with a check each family member living. Indicate the family member's present age or age at time of death. Indicate with a check any of the diseases from which family members suffer(ed). If the disease is a specific type, please write the type in the box (i.e., Cancer — Breast). Other diseases not listed may be hand written in the space provided.

	MOTHER'S		FATHER'S	
	MOTHER	FATHER	MOTHER	FATHER
Check if Living				
Age: Living or at death				
Alcoholism				
Allergies				
Alzheimer's Disease				
Arthritis				
Blood/Circulation				
Depression				
Cancer				
Diabetes				
Digestive System				
Drug Sensitivities				
Eye Disorder				
Heart Disease				
Hearing Disorder				
Hypertension				
Kidney Stones				
Liver Disorder				
Musculoskeletal				
Reproductive System				
Respiratory System				
Scoliosis				
Stroke				
Tuberculosis				
Ulcer Disease				
Urinary/Prostate				
Other:				

**TED L. EDWARDS, JR., M.D.**

4201 Bee Caves Road, Suite B-112, Austin, Texas 78746

**INTERNAL USE ONLY DO NOT COMPLETE**

SCANNED \_\_\_\_\_

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

### **ADDITIONAL INFORMATION**

Please use the space below for comments and additional information. If applicable, please note the section to which the comment refers.