TED L. EDWARDS, JR., M.D.
4201 Bee Caves Road, Suite B-112
Austin, Texas 78746

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)	[ ] MALE [ ] 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	RELATIONSHIP	PHONE
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?	RESPONSIBLE PARTY
[ ] CASH [ ] CHECK [ ] CREDIT CARD	[ ] SELF [ ] SPOUSE [ ] 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	LIVING WILL	LANGUAGES (S) SPOKEN
[ ] YES [ ] NO	[ ] YES [ ] NO	

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 lis 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)

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INTERNAL USE ONLY DO NOT COMPLETE

SCANNED ________

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

☐ *NONE*

MEDICATION ALLERGIES

☐ ☐ Aspirin ________ /
☐ ☐ Codeine ________ /
☐ ☐ Morphine ________ /
☐ ☐ Penicillin ________ /
☐ ☐ Sulfa ________ /
☐ ☐ X-Ray Dye ________ /

FOOD ALLERGIES

☐ ☐ Eggs ________ /
☐ ☐ Peanuts ________ /
☐ ☐ Shellfish ________ /

ENVIRONMENTAL ALLERGIES

☐ ☐ Dust ________ /
☐ ☐ Grass ________ /
☐ ☐ Molds ________ /
☐ ☐ Ragweed ________ /
☐ ☐ Animals ________ /
☐ ☐ Cedar ________ /
☐ ☐ Fire Ants ________ /
☐ ☐ Flying Insects ________ /

OTHER

________ /

☐ *See attached for more*

MEDICATIONS

Name | Dosage | Frequency

PRESCRIPTION MEDICATION

____
____
____
____
____
____

OVER THE COUNTER MEDICATION

____
____
____

SUPPLEMENTS

____
____
____

☐ *See attached for more*

SURGERIES

Yes/No | *Type | Year

☐ ☐ Tonsils ________ /
☐ ☐ Appendix ________ /
☐ ☐ Gallbladder ________ /
☐ ☐ Stomach* ________ /
☐ ☐ Kidney* ________ /
☐ ☐ Colon* ________ /
☐ ☐ Thyroid ________ /
☐ ☐ Hernia ________ /
☐ ☐ Breast* ________ /
☐ ☐ Uterus ________ /
☐ ☐ Ovaries* ________ /
☐ ☐ Prostate ________ /
☐ ☐ Joint Replacement ________ /
☐ ☐ Amputation* ________ /
☐ ☐ Tubal Ligation ________ /
☐ ☐ Vasectomy ________ /
☐ ☐ C-Section ________ /
☐ ☐ Hysterectomy ________ /
☐ ☐ Hemorrhoidectomy ________ /
☐ ☐ Other ________ /
☐ ☐ Other ________ /
☐ *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

Yes/No

☐ ☐ 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

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MEDICAL HISTORY

PATIENT NAME ______________________ DATE ________

GASTRO-INTESTINAL

Yes/No

- ☐ ☐ Digestive problems
- ☐ ☐ Heartburn
- ☐ ☐ Ulcers
- ☐ ☐ Nausea/vomiting
- ☐ ☐ Diarrhea
- ☐ ☐ Hemorrhoids
- ☐ ☐ Bloody stools
- ☐ ☐ Constipation
- ☐ ☐ Black bowl 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
☐ ☐	Head: Concussion	____
☐ ☐	Head: Laceration	____
☐ ☐	Head: Closed Injury	____
☐ ☐	Facial: Eye	____
☐ ☐	Facial: Ear	____
☐ ☐	Facial: Nose	____
☐ ☐	Facial: Jaw	____
☐ ☐	Neck: Fracture	____
☐ ☐	Neck: Injury	____
☐ ☐	Shoulder/Clavicle: Fracture	____
☐ ☐	Shoulder/Clavicle: Dislocation	____
☐ ☐	Arm: Fracture	____
☐ ☐	Arm: Dislocation	____
☐ ☐	Hand/Fingers: Fracture	____
☐ ☐	Hand/Fingers: Dislocation	____
☐ ☐	Torso: Rib Fracture	____
☐ ☐	Torso: Chest Injury	____
☐ ☐	Torso: Cardiac Injury	____
☐ ☐	Torso: Organ Trauma	____
☐ ☐	Torso: Back Injury	____
☐ ☐	Genitalia: Trauma	____
☐ ☐	Leg: Fracture	____
☐ ☐	Leg: Amputation	____
☐ ☐	Leg: Laceration	____
☐ ☐	Leg: Dislocation	____
☐ ☐	Foot/Ankle: Fracture	____
☐ ☐	Foot/Ankle: Amputation	____

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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/Pertussis/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	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:						

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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.