PATIENT REGISTRATION FORM

Peter M. Mowschenson, MD
1180 Beacon Street, Brookline, MA 02446
T: 617.735.8868 F: 617.730.9845

Personal Information

Last Name	First Name	MI
Address		
Street:		
City:	State:	Zip:
Home Phone	Cell Phone	Work Phone
Email		
Date of Birth	Marital Status	Spouse's Name
Primary Language	Occupation	
Primary Care Physician	Referred By	
Height (Ft, Inches)	Weight (lbs)	Sex (male/female)

The Federal Government has asked that we obtain the following additional information.
YOU MAY DECLINE IF YOU WISH.

Race: Please select one

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic
☐ Native Hawaiian
☐ White
☐ Other Race

Ethnicity: Please select one

☐ Hispanic
☐ Non-Hispanic

Insurance Information

PRIMARY INSURANCE

Insurance Company Name	Subscriber Number	Group Number
Subscriber		
Date of Birth	Relationship to Patient	

SECONDARY INSURANCE

Insurance Company Name	Subscriber Number	Group Number
Subscriber		
Date of Birth	Relationship to Patient	

Authorization

I authorize the release of medical information necessary to process medical benefits and I authorize payment of medical benefits to Peter Mowschenson, M.D. for services by the office.

Signed: _____

Date: _____

Medical History

Drug Allergies
Please list any allergies to medications you may have.

Your Pharmacy	City	Phone

Medications
Please list names of current medications. You don't need to list doses.

Smoking

Do/did you smoke?		
☐ Never	☐ Current	☐ Former

Former - How long ago did you stop smoking?

Current - How many cigarettes do you smoke daily?	Are you interested in quitting?

Alcohol

Do you drink alcohol?	
☐ Never	☐ Occasionally

How often do you drink?	How many drinks do you have each day?

Do you ever have more than 6 drinks a day?

Diseases of - Please indicate details for any that apply to you.

Heart	Lungs
Bowel	**Urinary System**
Skin	**Nervous System**
Blood or bleeding problems	**Any others of concern**

Family History - If possible please choose at least one family member who is alive or deceased and if possible complete the questions.

MOTHER		
☐ Alive	☐ Diabetes	☐ Thyroid Gland Malignancy
☐ Deceased	☐ Hypertension	☐ Hemmorrhage Postoperative
☐ Unkown	☐ Heart Disease	☐ Unkown

FATHER		
☐ Alive	☐ Diabetes	☐ Thyroid Gland Malignancy
☐ Deceased	☐ Hypertension	☐ Hemmorrhage Postoperative
☐ Unkown	☐ Heart Disease	☐ Unkown

SISTER		
☐ Alive	☐ Diabetes	☐ Thyroid Gland Malignancy
☐ Deceased	☐ Hypertension	☐ Hemmorrhage Postoperative
☐ Unkown	☐ Heart Disease	☐ Unkown

BROTHER		
☐ Alive	☐ Diabetes	☐ Thyroid Gland Malignancy
☐ Deceased	☐ Hypertension	☐ Hemmorrhage Postoperative
☐ Unkown	☐ Heart Disease	☐ Unkown