



**LANDMARK INTERNAL MEDICINE**  
7615 Clarington Cove,  
Southaven, MS 38671  
Phone: (662) 536-2500 Fax: (662) 536-2505

**PATIENT REGISTRATION**

**Patient**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle  
Initial: \_\_\_\_\_

Preferred Name if any: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Biological Gender: Male/Female Preferred Gender if any: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip:  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Race: \_\_Caucasian \_\_Black or African American\_\_ Asian \_\_ Native American/  
American Indian \_\_Alaskan Native/ Native Hawaiian \_\_ Other Pacific Islander  
\_\_Other\_\_ Decline to answer

Ethnicity: \_\_Hispanic or Latino \_\_ Non-Hispanic or non-Latino\_\_ Decline to answer

**Parent/Legal Guardian**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle  
Initial: \_\_\_\_\_

Preferred Name or Other Names used if any: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_ Mother \_\_ Father \_\_Stepmother\_\_ Stepfather\_\_ Custodial  
relative  
\_\_ Other

Biological Gender: Male/Female Preferred Gender if any: \_\_\_\_\_

Race: \_\_Caucasian \_\_Black or African American \_\_Asian \_\_Native American/  
American Indian \_\_Alaskan Native/ Native Hawaiian \_\_Other Pacific Islander  
\_\_Other \_\_Decline to answer

Ethnicity: \_\_Hispanic or Latino \_\_Non-Hispanic or non-Latino \_\_Decline to answer

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_  
Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email:  
\_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip:  
\_\_\_\_\_

Work Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Driver's License number: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Preferred method of Contact: \_\_Home phone  
\_\_Cell phone \_\_Email \_\_patient portal

Responsible Party (Guarantor): \_\_Yes \_\_No

**Parent/Legal Guardian**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle  
Initial: \_\_\_\_\_

Preferred Name or Other Names Used if any: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_Mother \_\_Father \_\_Stepmother \_\_Stepfather \_\_Custodial  
relative  
\_\_Other

Biological Gender: Male/Female Preferred Gender if any: \_\_\_\_\_

Race: \_\_Caucasian \_\_Black or African American \_\_Asian \_\_Native American/

American Indian \_\_Alaskan Native/ Native Hawaiian \_\_ Other Pacific Islander  
\_\_Other\_\_ Decline to answer

Ethnicity: \_\_Hispanic or Latino \_\_ Non-Hispanic or non-Latino\_\_ Decline to answer

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_

Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email:  
\_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_

Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Driver's License number: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Preferred method of Contact: \_\_Home phone \_\_ Cell phone \_\_ Email \_\_ Patient Portal

Responsible Party (Guarantor):\_\_ Yes \_\_ No

**Responsible Party/ Guarantor if not a Parent or Legal Guardian**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle  
Initial: \_\_\_\_\_

Other Names Used if any: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_

Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email:  
\_\_\_\_\_

Work Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Driver's License number: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Preferred method of Contact: \_\_Home phone \_\_Cell phone \_\_ Work phone \_\_Email

### **Emergency Contact**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Other Names Used if any: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Driver's License number: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Preferred method of Contact: \_\_Home phone \_\_Cell phone \_\_ Work phone \_\_Email

### **Insurance Information**

Primary Insurance Name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Rx Bin Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Rx Bin Number: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

**Credit Card Information**

\_\_ Master Card \_\_ Visa \_\_ Amex

Name on Credit/Debit Card: \_\_\_\_\_

Credit/ Debit Card number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV: \_\_\_\_\_

**Pharmacy Information**

Name of Preferred Pharmacy: \_\_\_\_\_ Phone:  
\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip:  
\_\_\_\_\_

Name of Secondary Pharmacy: \_\_\_\_\_ Phone:  
\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip:  
\_\_\_\_\_

**Preferences**

Any religious or cultural preferences for receiving medical care that we should be aware of? \_\_\_\_\_

Any preferred method of learning and receiving information regarding medical care? \_\_\_\_\_

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physician and staff of LANDMARK INTERNAL MEDICINE to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized

services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize LANDMARK INTERNAL MEDICINE to release information requested by insurance company and/or its representatives. I fully understand this agreement, and my consent will remain in effect until cancelled by me in writing.

Signature of Patient/Parent/Legal Guardian:

\_\_\_\_\_

Name of Patient/Parent/Legal Guardian: \_\_\_\_\_ (Please Print)

Relationship to Patient: \_\_\_\_\_ Date:

\_\_\_\_\_

### Medical History

Check all that the patient has experienced and year and month of onset

- | ___ Allergies                      | Mo/YR |
|------------------------------------|-------|
| ___ Food allergies                 |       |
| ___ Animal allergies               |       |
| ___ Seasonal allergies             |       |
| ___ Medication allergy             |       |
| ___ Insect allergies               |       |
| ___ Other allergies                |       |
| ___ Anemia                         | _____ |
| ___ Asthma                         | _____ |
| ___ Autoimmune diseases            | _____ |
| ___ Birth difficulties             | _____ |
| ___ Blood disorders                |       |
| ___ Bone disease                   |       |
| ___ Cancer                         |       |
| ___ Celiac disease                 |       |
| ___ Cerebral Palsy                 |       |
| ___ Constipation                   |       |
| ___ Cystic fibrosis                |       |
| ___ Eczema                         |       |
| ___ Endocrine or hormonal problems |       |
| ___ Eosinophilic Esophagitis       |       |
| ___ Food Intolerance               |       |

- Gastroesophageal Reflux
- Genetic disorders
- Growth issues
- Heart disease
- Hearing problems, or wears hearing aids
- Hernia
- Immune deficiency
- Joint pain
- Kidney disease
- Migraine Headaches
- Prematurity
- Scoliosis
- Seizure
- Sleep disturbances
- Stroke
- Thyroid problems
- Vision problems, or wears eye glasses
- Chronic Vomiting
- Weight issues

#### Developmental and Psychiatric History

- ADHD
- Anxiety
- Autism
- Aggression/Irritability
- Conduct disorder
- Depression
- Developmental Delays
- Eating disorder
- Feeding difficulties
- Learning disorders
- Oppositional Defiant Disorder
- Self harm or cutting
- Substance abuse
- Suicide attempt or ideation
- Tourette's Syndrome

#### Services and Therapy Interventions Received

- Individualized Education Plan (IEP) in school
- 504 Plan in school

- Early Intervention Services in early childhood
- Individualized Family Service Plan (IFSP)
- Speech therapy
- Occupational therapy
- Physical therapy
- Psychotherapy
- Applied Behavioral Analysis (ABA)
- Respite Care

**Surgeries**

- Circumcision (if applicable)
- Adenoidectomy
- Tonsillectomy
- Appendectomy
- Ear surgery
- Bowel resection
- Heart surgery
- Hernia repair
- Surgery for fractures
- Other surgery, please specify \_\_\_\_\_

Please list hospitalizations with reason for hospitalization, and admission and discharge dates:

Reason for hospitalization	Admission date	Discharge date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Social History**

Ethnicity:  Hispanic or Latino  Non-Hispanic or non-Latino

Parents' Relationship:  Married  Divorced  Widowed  Single  Separated

Patient resides with:

- Primary  Mother  Father  Both Parents  Other
- Secondary  Mother  Father  Both Parents  Other  Not Applicable
- Number of brothers who live in the home: \_\_\_\_\_

Number of sisters who live in the home: \_\_\_\_\_  
Number of siblings who no longer live at home: \_\_\_\_\_

Childcare: \_\_ Mother \_\_ Father \_\_ Grandparent/s \_\_ Nanny \_\_ Daycare \_\_ Other

Tobacco Exposure \_\_ Yes \_\_ No          Smokers at Home \_\_ Yes \_\_ No

Pets \_\_ Yes \_\_ No; If yes, please specify: \_\_\_\_\_

International travel to: 1) \_\_\_\_\_ Dates: From \_\_\_\_\_ to \_\_\_\_\_  
2) \_\_\_\_\_ Dates: \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_  
3) \_\_\_\_\_ Dates: \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_

### Medication History

Name	Strength	Form	# of times/day
<i>For example</i> <i>Amoxicillin</i>	<i>250 mg</i>	<i>chewable</i>	<i>three times a day</i>
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____
7) _____	_____	_____	_____
8) _____	_____	_____	_____
9) _____	_____	_____	_____
10) _____	_____	_____	_____

### Medication Allergy

Medication	Reaction
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____
6) _____	_____

### Family history

Mother    Father    Brother    Sister    Grandmother

Grandfather  
Allergies  
Autoimmune disease  
Arthritis  
Asthma

Blood disorder  
Clotting disorder  
Cancer  
Celiac disease  
Constipation  
Cystic fibrosis  
Diabetes  
Eczema/ skin problems  
Food intolerance  
Gastroesophageal reflux  
Genetic disorders  
Heart disease  
Hearing impairment  
Hypertension  
Immune deficiency  
Kidney disease  
Migraine headache  
Seizure  
Stroke  
Sleep disturbances  
Thyroid problems  
Vision problems  
Mental illnesses  
    Suspected or known ADHD  
    Suspected or known autism  
    Anxiety  
    Bipolar disorder  
    Depression  
    Suicidal attempt  
    Eating disorder  
    Substance abuse