Adventist HealthCare Imaging

THE GEORGE WASHINGTON UNIVERSITY MEDICAL FACULTY ASSOCIATES MFA

Patient Registration Form

Last Name _____ First Name _____ Middle Initial ____ Suffix ____ DOB _____

Preferred Language: ❑ English ❑ Spanish ❑ Chinese ❑ Other: _____

We are required to obtain the following information in order to be compliant with Federal Government Electronic Health Records program.

Race

❑ American Indian or Alaska Native ❑ Asian ❑ Black/African American ❑ Hispanic
❑ Native Hawiian or Pacific Islander ❑ White ❑ Other Race ❑ Patient declined to specify

Ethnicity

❑ Hispanic or Latino ❑ Not Hispanic or Lation ❑ Patient declined to specify

Smoking Status

❑ Current everyday smoker ❑ Current someday smoker ❑ Former smoker ❑ Never smoker
❑ Smoker status unknown ❑ Unknown if ever smoked ❑ Heavy tobacco smoker ❑ Light tobacco smoker

Do you have any known allergies? ❑ Yes ❑ No

If yes, please list: _____

Current Medications Referring Physician Pharmacy

If you have a medication list, we can copy