PATIENT REGISTRATION FORM

Name_____ Today's Date_____
Last First M.I.

Mailing Address_____ Age _____
Number, Street, Apartment Number

_____
City State Zip code

Home Phone (____)_____ Work Phone (_____)_____ Cell Phone (_____) _____

E-Mail _____

Date of Birth____/____/____ SS #_____ Marital Status_____ Gender _____

Employer_____ Retired_____ Full Time Student_____ Part Time Student _____

Spouse's Name:_____ Employer_____ Work # _____

Person to notify in case of emergency_____ Phone _____

May we leave a message on your home/cell answering machine? _Y _N
May we leave a message for you at work to call us? _Y _N
May we discuss your medical condition with another person? _Y _N
If yes, with whom_____ Relationship _____

How did you hear about our practice? Please be specific (search engine, magazine, newspaper)_____

Referring Physician (if there is one) _____

Current (or previous) Dermatologist_____ Primary Care Physician _____

Pharmacy (name, city, and street; exact address not needed)_____

Primary reason for today's visit _____

Only complete the section below if you are not the primary insured party or are missing your insurance card.

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Policy Holder (if different from patient or responsible party) _____

Policy Holder's Date of Birth____/____/____ SS# _____

Employer of Policy Holder_____ Work Phone(_____)_____

Patient's Relationship to Policy Holder _____

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If patient is a minor please enter responsible party information. (Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.)

Name_____ SS# _____
Last First M.I.

Address_Number, Street, Apartment Number

_____
City State Zip

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Please turn

PATIENT REGISTRATION FORM

MEDICATIONS (name and dose)	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

ALLERGIES (please list with reactions)	
1.	3.
2.	4.

SKIN CANCER/FAMILY	YES	NO
Have you ever had basal cell or squamous cell carcinoma (BCC or SCC)?		
Date/location:_____		
Have you ever had melanoma?		
Date/location:_____		
Any family members with melanoma?		
Date/location:_____		
Any family members with other skin cancer?		
List:_____		

PREGNANCY AND NURSING		
Are you currently pregnant, nursing, or attempting conception?	YES	NO
If pregnant, how many weeks: _____		

SOCIAL HISTORY	YES	NO
Do you smoke?		
- if yes, how many packs per day? _____		
Do you drink alcohol?		
Do you use recreational drugs?		
Do you exercise?		

SURGICAL HISTORY	YES	NO
Do you take Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, aspirin, or other blood thinners? If yes, circle which ones.		
Do you have any artificial joints, heart valves, or other implanted material? If yes, please list:		
Do you routinely take antibiotics before dental procedures?		
Have you ever had a reaction to anesthesia?		
Do you have liver or kidney disease?		
Do you have a bleeding or clotting disorder?		
Do you have a pacemaker or defibrillator?		

PAST MEDICAL HISTORY	YES	NO
Eczema		
Psoriasis		
Diabetes		
Heart disease		
Have you ever tested positive for HIV/AIDS?		
Have you ever tested positive for Hepatitis A/B/C?		
Thyroid disease		
Sexually transmitted diseases		
Cancer (other than skin)		
High blood pressure		
Herpes simplex (cold sores)		
Tuberculosis		
Other conditions (please list): _____		

PAST SURGICAL HISTORY (please list	
1.	5.
2.	6.
3.	7.
4.	8.

To the best of my knowledge, the above information is accurate and complete.

Patient Signature:_____DATE: _____

Reviewed by (provider signature):_____DATE:_____MA Initials: __

Please turn