

PATIENT REGISTRATION FORM

Name				Today's Date
Last	First		M.I.	
Mailing Address				_Age
	nber, Street, Apartment Number			
City	State		Zip code	
Home Phone ()	Work Phone ()_	Cell P	hone (
E-Mail				
Date of Birth / /	SS #	_Marital Status	Gender	
Employer	Retir	edFull Time St	udentF	Part Time Student
Spouse's Name:	Empl	loyer	Wo	ork #
Person to notify in case of em	nergency		Phone	
May we leave a message for y May we discuss your medical	your home/cell answering maching you at work to call us? I condition with another person?	_Y1 _Y1	N N	
How did you hear about our J	practice? Please be specific (sear	ch engine, magazine,	newspaper)	
Referring Physician (if there is	s one)			
Current (or previous) Dermato	ologist	Primary Care Phys	sician	
Pharmacy (name, city, and str	eet; exact address not needed)			
Primary reason for today's visi	it			
*********	nplete the section below if you are not the print ************************************	******	******	*******
Policy Holder's Date of Birth	/ / SS#			
Employer of Policy Holder		V	Work Phone()
Patient's Relationship to Poli	icy Holder			
**********	**********	******	*****	********
If patient is a minor pleas presenting the minor for care	e enter responsible party inf e is the responsible party.)	formation. (Note: We	do not bill a	bsent parents, the adult
Name			SS#	
Last	First		M.I.	
Address_Number, Street, Apartm	ent Number			
City	State	Zip		
Home Phone ()	Work Phone ()	Call Phone	0(





PATIENT REGISTRATION FORM

1.	MEDICATIONS (name and dose)				SURGICAL HISTORY		NO
## special control of the program of	1.	7.					
3. 9. 4. 10. 5. 11. 6. 12. 12. 13. 14. 15. 15. 12. 15. 15. 12. 15. 16. 12. 15. 16. 16. 16. 17. 17. 17. 18. 18. 18. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19	2.						
5. 11. 6. 12. Do you routinely take antibiotics before dental procedures? Have you ever had a reaction to anesthesia? Do you have a pacemaker or defibrillator? Have you ever had basal cell or squamous cell carcinoma (BCC or SCC)? Date/location: PAST MEDICAL HISTORY YES NO Date/location: Date/location: Date/location: Date/location: Date/location: Have you ever had melanoma? Date/location: Date/location: Have you ever tested positive for HIV/AIDS? Have you ever tested positive for HI	3.	9.			If yes, circle which ones.		
ALLERGIES (please list with reactions) 1.	4.						
Do you routinely take antibiotics before dental procedures? Do you routinely take antibiotics before dental procedures?	5.	11.			or other implanted material? If yes, please list:		
denial procedures? denial procedures? Have you ever had a reaction to anesthesia? Do you have a bleeding or clotting disorder? Do you have a pacemaker or defibrillator?	6.	12.					
Have you ever had a reaction to anesthesia? Do you have a bleeding or clotting disorder?	ALLERGIES	(please list with r	eactio	ns)			
2. 4. Do you have a liver or kidney disease? Do you have a bleeding or clotting disorder? Do you have a pleeding or clotting disorder? Do you have a pleeding or clotting disorder? Do you have a pacemaker or defibrillator? PAST MEDICAL HISTORY YES NO Date/location: Have you ever had melanoma? Date/location: Have you ever had melanoma? Date/location: Any family members with melanoma? Date/location: Have you ever tested positive for HIV/AIDS? Have you ever tested positive for Hepatitis A/BVC? Thyroid disease Sexually transmitted diseases Cancer (other than skin) High blood pressure Herpes simplex (cold sores) Tuberculosis Other conditions (please list): SOCIAL HISTORY YES NO Do you smoke? Do you warney packs per day? Do you drink alcohol? Do you drink alcohol? Do you drink alcohol? Do you exercise? To the best of my knowledge, the above information is accurate and complete. DATE: D					Have you ever had a reaction to anesthesia?		
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? If pregnant, how many weeks: SOCIAL HISTORY YES NO Do you smoke? If yes, how many packs per day? Do you swo serereational drugs? Do you exercise? To the best of my knowledge, the above information is accurate and complete. PAST MEDICAL HISTORY YES NO PAST MEDICAL HISTORY YES NO Diabetes Heart 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.							
Do you have a pacemaker or defibrillator?		1					
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? If pregnant, how many weeks: SOCIAL HISTORY YES NO Do you wmoke? - if yes, how many packs per day? Do you use recreational drugs? Do you exercise? To the best of my knowledge, the above information is accurate and complete. PAST MEDICAL HISTORY YES NO Bezema 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. 2. 6. 3. 7. 4. 8. To the best of my knowledge, the above information is accurate and complete. Patient Signature: DATE: DATE:	SKIN CANCER/FAMILY		YES	NO			
Date/location:	Have you ever had	d basal cell or squamous					1
Psoriasis Diabetes Diabetes Diabetes Diabetes Diabetes Heart disease Have you ever tested positive for HIV/AIDS? Have you ever tested positive for HIV/AIDS? Have you ever tested positive for HIV/AIDS? Have you ever tested positive for Hepatitis A/B/C? Thyroid disease Sexually transmitted diseases Sexually transmitted diseases Cancer (other than skin) High blood pressure Herpes simplex (cold sores) Tuberculosis Other conditions (please list):	cell carcinoma (Bo	CC or SCC)?			PAST MEDICAL HISTORY		NO
Date/location:	Date/location:				Eczema		
Date/location: Any family members with melanoma? Date/location: Any family members with other skin cancer? List: Thyroid disease Sexually transmitted diseases Sexually transmitted diseases Cancer (other than skin) High blood pressure Herpes simplex (cold sores) Tuberculosis Other conditions (please list):							
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? If pregnant, how many weeks: SOCIAL HISTORY Do you smoke? Do you drink alcohol? Do you use recreational drugs? Do you exercise? The 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: DATE: DATE:		d melanoma?					
Date/location: Any family members with other skin cancer? List: PREGNANCY AND NURSING Are you currently pregnant, nursing, or attempting conception? If pregnant, how many weeks: SOCIAL HISTORY Do you smoke? - if yes, how many packs per day? Do you use recreational drugs? Do you use recreational drugs? To the best of my knowledge, the above information is accurate and complete. Patient Signature: DATE: 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,							
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Are you currently pregnant, nursing, or attempting conception? If pregnant, how many weeks:	PREGNANCY	AND NURSING					+
attempting conception? If pregnant, how many weeks:							
If pregnant, how many weeks:Other conditions (please list):Other conditions (please list):			YES	NO	Herpes simplex (cold sores)		
SOCIAL HISTORY Do you smoke? - if yes, how many packs per day? Do you drink alcohol? Do you use recreational drugs? Do you exercise? PAST SURGICAL HISTORY (please list 1.	attempting conception?						
SOCIAL HISTORY Do you smoke? - if yes, how many packs per day? Do you drink alcohol? Do you use recreational drugs? Do you exercise? To the best of my knowledge, the above information is accurate and complete. Patient Signature: DATE:	If pregnant, how i	many weeks:			Other conditions (please list):		
Do you smoke? - if yes, how many packs per day? Do you drink alcohol? Do you use recreational drugs? Do you exercise? To the best of my knowledge, the above information is accurate and complete. Past SURGICAL HISTORY (please list 1.	r 18 11 17						
- if yes, how many packs per day? Do you drink alcohol? Do you use recreational drugs? Do you exercise? 1.	SOCIAL HIST	ГORY	YES	NO			
Do you drink alcohol? Do you use recreational drugs? Do you exercise? 2.	Do you smoke?				PAST SURGICAL HISTORY (ple	ase li	\mathbf{st}
Do you use recreational drugs? Do you exercise? 3. 4. 8. To the best of my knowledge, the above information is accurate and complete. Patient Signature: DATE:	- if yes, how many	packs per day?			1. 5.		
To the best of my knowledge, the above information is accurate and complete. Patient Signature:DATE:							
To the best of my knowledge, the above information is accurate and complete. Patient Signature:DATE:							
Patient Signature:DATE:	Do you exercise?				4.		
Patient Signature:DATE:	To the hest of	of my knowledge.	the ah	ove in	oformation is accurate and comple	te.	
	_ 0 1220 2000 (40				
	Patient Signature:			DATE.			
	Patient Sign	ature:			DAIE;		