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PATIENT REGISTRATION FORM

LAST NAME:	FIRST NAME:	MI:	DATE:	
ADDRESS:	CITY:	STATE:	ZIP CODE:	
DATE OF BIRTH:	AGE:	SEX: M F	SS#:	EMAIL:
HOME PHONE:	WORK PHONE:	CELL:	MARITAL STATUS: S M D W SEP	
YOUR OCCUPATION:	REFERRED BY:			

PLEASE PROVIDE US WITH A FAMILY MEMBER, SPOUSE OR A FRIEND TO WHOM WE MAY DISCLOSE PERSONAL HEALTH INFORMATION OR CONTACT IF NEEDED.

NAME _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ PATIENT SIGNATURE: _____

PRIMARY INSURANCE PLAN:	GROUP NO:	POLICY NO:	
INSURANCE CLAIMS ADDRESS:		CLAIMS PHONE #:	
POLICY HOLDER'S NAME:		RELATIONSHIP TO PATIENT:	
DATE OF BIRTH:	SEX: M F	SS#:	

SECONDARY INSURANCE PLAN:	GROUP NO:	POLICY NO:	
INSURANCE CLAIMS ADDRESS:		CLAIMS PHONE #:	
POLICY HOLDER'S NAME:		RELATIONSHIP TO PATIENT:	
DATE OF BIRTH:	SEX: M F	SS#:	

PLEASE REMEMBER THAT INSURANCE IS A METHOD OF REIMBURSING THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. IT IS YOUR RESPONSIBILITY TO PAY FOR ANY DEDUCTIBLE OR CO-PAYMENT.

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT FOR ANY CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE TO WHICH I AM ENTITLED, INCLUDING UNDER MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS TO THE ABOVE-NAMED PROVIDER(S).

X_____ DATE: _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF PATIENT IS UNDER THE AGE OF 18 YEARS

I ACKNOWLEDGE RECEIPT OF YOUR WRITTEN PRIVACY PRACTICES

SIGNATURE:_____ DATE:_____

PURPOSE OF YOUR VISIT:

Past Medical History (Please check all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
BPH
Breast Cancer
CHF
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Joint Replacement
Hearing Loss
Heart Valve Replacement
Hepatitis / HIV / AIDS
High Blood Pressure
High Cholesterol
Thyroid Problems (Hyper or Hypo)
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Pacemake / Defibrillator
NONE OTHER

Past Surgical History

Skin Disease History (Please check all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
NONE OTHER

Family History (Please check all that apply)

Melanoma Mother Father Sister Brother Daughter Son Other

Did you receive the Flu Vaccine this past flu season? YES NO
Have you ever received the Pneumonia Vaccine? YES NO

Medications (Please list all current medications or attached a separate list)

Medication	Dosage	Frequency

Medication	Dosage	Frequency

Allergies (Please list all allergies)

Cigarette Smoking

Never Smoked
Quit: Former Smoker
Smokes Less Than 1 Daily
Smokes Daily

Daily Alcohol Intake

None
Less Than 1 Drink
1 - 2 Drinks
3 or More Drinks

Do you have any of the following?

Problems With Bleeding YES NO
Problems With Healing YES NO
Problems With Scaring YES NO

Do you have a Living Will? YES NO If so, who is your surrogate? NAME:

Pharmacy Name:	
Address:	City:
Pharmacy Phone:	
Mail Order Pharmacy:	Mail Order Phone Number:
Primary Care Physician:	
Address:	City:
Primary Care Physician Phone:	

When did you last see your Primary Care Physician? Month Year