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

Past Surgical History

Skin Disease History (Please check all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever / Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	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 Scarring	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