

Patient Registration

Date: _____

Please Print Clearly

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: _____ Date of Birth: ___/___/___ Age: _____ Social Security: _____-_____-_____

Address: _____

City: _____ State: _____ Zip Code _____-_____

Home Phone #: _____ Work Phone #: _____ Cell Phone: _____

Circle preferred number: HOME WORK CELL

Email Address: _____

Please Circle Race: American Indian African American or Black Native
Native Hawaiian/Other Pacific White Other: _____

Ethnicity: *Circle One*: Hispanic or Latino Not Hispanic or Latino

Primary Language: _____

Employer: _____ Occupation: _____

INSURANCE

Primary Insurance: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ Relation: _____

Policy Holder's SS#: _____-_____-_____ Policy Holder's Date of Birth: ___/___/___

Specialist Copay: _____

Secondary Insurance: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ Relation: _____

Policy Holder's SS#: _____-_____-_____ Policy Holder's Date of Birth: ___/___/___

Specialist Copay: _____

Pharmacy and Referrals

Pharmacy Name, Street Address & Telephone

#: _____

Primary Care Physician's Name, Location & Telephone

#: _____

Patient Name: _____

Date of Birth: _____

Power of Attorney(POA)(If applicable, please provide copy):

Name: _____ Phone: _____

Relation: _____

Emergency Contact:

Name: _____ Phone: _____

Relation: _____

HIPAA ACKNOWLEDGEMENT:

I give permission to discuss any of my financial and medical issues with the following person/s.

Person/s Name: _____ Relationship: _____

Phone Number: _____

Patient Signature: _____

I attest that my personal information and insurance information is accurate. Failure to provide accurate insurance information may result in reject claims.

I further attest that I have filled out the attached self-assessment medical questionnaire as completely as possible. I am wholly responsible for information that is omitted and hold the provider harmless for medical decisions made without this information.

Patient/Legal Guardian Signature

DATE

Minor Patients only:

Guardian/Responsible Party: _____

Relation: _____

Birth Date ____/____/____

Social Security # ____-____-____

Tel# _____

Address (If different from patient's): _____

Reason for Today's Visit

Concern: _____

Duration: _____

Prior Treatment: _____

Concern: _____

Duration: _____

Prior Treatment: _____

Patient Name: _____

Date of Birth: _____

Medical History

CIRCLE YES/NO FOR ALL OF THE FOLLOWING AND SPECIFY IN SECTION BELOW

Anxiety	Yes	No	S izures	Yes	No
Arthritis	Yes	No	CVA/Stroke	Yes	No
Asthma	Yes	No	Congestive Heart Failure	Yes	No
Atrial Fibrillation	Yes	No	Liver Disease- Hepatitis	Yes	No
Bone Marrow Transplant	Yes	No	Liver Disease- Hepatitis A	Yes	No
BPH	Yes	No	Liver Disease- Hepatitis B	Yes	No
Breast Cancer	Yes	No	Liver Disease- Hepatitis C	Yes	No
Colon Cancer	Yes	No	Parkinson's	Yes	No
COPD	Yes	No	Autoimmune Disorder	Yes	No
Coronary Artery Disease	Yes	No	Lupus	Yes	No
Depression	Yes	No	Rheumatoid Arthritis	Yes	No
Diabetes	Yes	No	Peripheral artery disease	Yes	No
End Stage Renal Disease	Yes	No	Scleroderma	Yes	No
GERD	Yes	No	Sjorgren's syndrome	Yes	No
Hearing Loss	Yes	No			
Hepatitis	Yes	No	OTHER: _____		
Hypertension	Yes	No	_____		
HIV/AIDS	Yes	No	_____		
Hypercholesterolemia	Yes	No	_____		
Hyperthyroidism	Yes	No	_____		
Hypothyroidism	Yes	No	_____		
Leukemia	Yes	No	_____		
Lung Cancer	Yes	No	_____		
Lymphoma	Yes	No	_____		
Prostate Cancer	Yes	No	_____		
Radiation Treatment	Yes	No	_____		

Alerts(Circle yes or no)

Allergy to adhesive	Yes	No	Defibrillator	Yes	No
Allergy to lidocaine	Yes	No	MRSA	Yes	No
Artificial heart valve	Yes	No	Pacemaker	Yes	No
Artificial Joints within last two years	Yes	No	Premedication prior to procedures	Yes	No
Blood thinners	Yes	No	Rapid heartbeat with epinephrine	Yes	No

Allergies to medications (Please list all known medication allergies as well as the type of reaction)

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Sensitivity to Epinephrine: Yes _____ No _____ Allergy to Latex: Yes _____ No _____

Allergy to Betadine, Iodine, Shellfish, IV dye Yes _____ No _____

Patient Name: _____

Date of Birth: _____

Influenza Vaccine(FLU) Yes No If yes, when was the last time vaccine was received? _____

Pneumonia Vaccine: Yes No If yes, when was the last time vaccine was received? _____

Personal History of Skin Cancer: (*Basal Cell Carcinoma, Squamous Cell Carcinoma, Melanoma*)

Type:	Year:	Treatment:
_____	_____	_____
_____	_____	_____

Sun Exposure History:

Current Outdoor Occupation Yes: _____ No: _____ Number of Years: _____

Former Outdoor Occupation Yes: _____ No: _____ Number of Years: _____

History of Blistering Sunburns Yes: _____ No: _____ Approximate Number: _____

Organ Transplant (specific Type):

Type: _____ Year: _____

Stem Cell Transplant: Yes: _____ No: _____

Are you taking Immunosuppressive Medications? Yes: _____ No: _____

Medications (Please list all medications you are currently taking: (or attach medication list))

Drug: _____ Dosage: _____ Frequency: _____

Drug: _____ Dosage: _____ Frequency: _____

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Drug: _____ Dosage: _____ Frequency: _____

Female Patients Only

Please complete the following

Are you Pregnant Yes: _____ No: _____ Breastfeeding? Yes: _____ No: _____

Are you on birth control? Yes: _____ No: _____ Do you have regular menstrual cycles? Yes: _____ No: _____

When was your last menstrual cycle? _____

Minor Patients Only (18 or under):

Height: _____ Weight _____ lbs

Patient Name: _____

Date of Birth: _____

Social History

Smoking Status: Circle One

Never

Current Some Day Smoker

Cigar Smoker

Former Smoker

Current Every Day Smoker

Chewing Tobacco User

If applicable:

When did you start smoking: _____

Number of packs per day: _____

When did you quit smoking: _____

Total Number of years smoking: _____

Alcohol Consumption: Circle one

None

1-2 Drinks per day

Other: _____

Less than 1 drink per day

3+ Drinks per Day

Other Social History: Circle One

Not Sexually Active

Drug Use

Sexually Active with one partner

IV Drug Use

Sexually Active with multiple partners

Family History

Please list any family history of illness or disease:

Disease/ Illness : _____ Relation: _____ Deceased? Yes No

Disease/ Illness : _____ Relation: _____ Deceased? Yes No

Family History of Skin Cancer:

Type:

Family Member and approximate age of diagnosis:

Basal Cell Carcinoma: _____

Squamous Cell Carcinoma: _____

Melanoma: _____

Additional Symptoms

Circle Yes/No

Problems with bleeding	Yes/No	Problems with healing	Yes/No	Problems with scarring	Yes/No
Rash	Yes/No	Immunosuppression	Yes/No	Hay Fever	Yes/No
Chest Pain	Yes/No	Fever and Chills	Yes/No	Night sweats	Yes/No
Unintended weight loss	Yes/No	Thyroid Problems	Yes/No	Sore Throat	Yes/No
Abdominal Pain	Yes/No	Bloody Stool	Yes/No	Bloody Urine	Yes/No
Muscle Weakness	Yes/No	Neck Stiffness	Yes/No	Headaches	Yes/No
Seizures	Yes/No	Cough	Yes/No	Shortness of Breath	Yes/No
Wheezing	Yes/No	Anxiety	Yes/No	Depression	Yes/No
Blurry Vision	Yes/No	Joint Aches	Yes/No		