NAME____ D.O.B.______________

Name of primary care physician if you have one____

What brought you to the office today? (please check appropriate box)

______ Routine skin check
______ Change in a mole
______ Rash
______ Acne
______ Wart

_____ Other (please explain)
____

List all medications you currently take:____

____

PERSONAL HISTORY

Illnesses: Have you ever had (please encircle ALL answers)

Skin Cancer	No	Yes
Chicken Pox	No	Yes
Rheumatic Fever	No	Yes
Heart disease	No	Yes
Arthritis and rheumatism	No	Yes
Any bone or joint disease	No	Yes
Raynaud's Syndrome	No	Yes
Gonorrhea or syphilis	No	Yes
Jaundice or hepatitis	No	Yes
AIDS or HIV positive	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
High or low blood pressure	No	Yes
Colitis or other bowel disease	No	Yes
Hay fever or asthma	No	Yes
Hives or eczema or psoriasis	No	Yes
Frequent infections or boils	No	Yes
Other cancer	No	Yes

If yes, what type:

Have you ever been advised to take an antibiotic before a procedure such as dental work?	No	Yes
Do you take aspirin or aspirin containing products on a regular basis?	No	Yes
Have you ever had a bleeding disorder?	No	Yes

ALLERGIES

Are you allergic?

Aspirin	No	Yes
Codeine	No	Yes
Betadine	No	Yes
Lidocaine	No	Yes
Penicillin	No	Yes
Sulfa	No	Yes
Mycins/other antibiotic	No	Yes
Merthiolate (Mercurochrome)	No	Yes
Other Drugs_______________	No	Yes
Foods____________________	No	Yes
Adhesive tape	No	Yes
Nail polish/other cosmetics	No	Yes
Tetanus Antitoxin or serums	No	Yes

Have you ever had a blood or plasma transfusion	No	Yes

SURGERY you have had

DO YOU HAVE SYMPTOMS OF:

Joint pains	No	Yes
Swelling of any joints	No	Yes
Redness or heat of any joint	No	Yes
Growth in neck or throat	No	Yes
Brittleness of nails	No	Yes
Dryness of skin	No	Yes
Easy bruising	No	Yes
Inability to stand heat	No	Yes
Inability to stand cold	No	Yes
Change in hair texture	No	Yes
Change in skin texture	No	Yes

I authorize you to give me reasonable and proper medical care by today's standards.

Patient signature____ Date__________________
or guardian if minor

PATIENT REGISTRATION FORM

Patient Name:______________________________ Date: ___-___-_____
First Middle Last Month Day Year

Prefer to be called:____________________ Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Birthdate:_____-_____-_________ Age:______ Sex: ☐ Male ☐ Female
Month Day Year

Social Security Number:____________________

Home Address:______________________________
Street# Street Name Apt#

____
City State Zip

Phone #:( )__________ #:( ) __________( )__________
perferred ☐ Home ☐cell ☐work

Where should the statement of account be sent if different from above:

____
Name Address City State Zip

Card Holder Name:____________________ Social Security #:__________
First Middle Last

Card Holder Birthdate:_____-_____-_______Employer:__________________

Do you have prescription coverage?: ☐Yes ☐ No

Primary Care Physician ____________________ and ____________________
Name phone numer

Who referred you to this office? (Physician, Relative, Friend, Co-worker etc)
Name: ______________________________

Incase of emergency contact______________________________

Please present insurance cards and photo ID to medical receptionist so copies can be made.

Do we have your permission to:
Leave a message on your answering machine at home? Yes No
Leave a message at your place of employment? Yes No
Discuss your medical condition with any member of your household? Yes No

If yes, whom:____________________ Relationship:______________

Patient signature______________________________ **Date:**____________________