# Patient Registration Form

Date of Appointment: _____

## Patient Information

| Patient's First Name | Middle Name | Last Name (as it appears on insurance card or ID) |
|---|---|---|
| | | |

| Sex | Marital Status | Date of Birth (Age) | Social Security Number |
|---|---|---|---|
| | | | |

| Patient's Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Mobile Phone | Email Address |
|---|---|---|
| | | |

| Referred by | Primary Care Physician | Primary Care Physician Phone |
|---|---|---|
| | | |

| Pharmacy | Pharmacy Phone | Pharmacy Address |
|---|---|---|
| | | |

### Patient Employer/School Information

| Employer/School | Occupation | Employer/School Phone |
|---|---|---|
| | | |

| Employer/School Address | City | State | Zip |
|---|---|---|---|
| | | | |

### Emergency Contact Information

| Emergency Contact Name | Emergency Contact Phone | Relation to Patient |
|---|---|---|
| | | |

## Billing and Insurance

### Primary Health Insurance

| Insurance Company | Plan |
|---|---|
| | |

| Plan Number | Group Number | Insured's Employer/School |
|---|---|---|
| | | |

| Insured's Name (as it appears on insurance card or ID) | Relation to Patient | Insured's Phone Number |
|---|---|---|
| | | |

| Insured's Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Insured's Social Security Number | Insured's Birthdate | |
|---|---|---|
| | | |

### Secondary Health Insurance

| Insurance Company | Plan |
|---|---|
| | |

| Plan Number | Group Number | Insured's Employer/School | Insured's Social Security Number |
|---|---|---|---|
| | | | |

| Insured's Name (as it appears on insurance card or ID) | Relation to Patient | Insured's Phone Number |
|---|---|---|
| | | |

### Responsible Party

| Billing Name (if other than patient) | Phone | Relation to Patient |
|---|---|---|
| | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

_____ _____

Signature of Patient or Authorized Guardian | Date

Name _____ Gender _____ Age _____ Date of Appointment: _____

## Reason for Visit

What brings you to the office today?

Please describe any previous skin problems you have had.

## Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

| Name | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

## Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

| Name | Reaction |
|---|---|
| | |
| | |

## Skin

Do you have any of the following?

☐ Abnormal Moles ☐ Cold Sores ☐ Psoriasis
☐ Acne ☐ Dry / Sensitive Skin ☐ Rash
☐ Boils ☐ Eczema ☐ Rosacea
☐ Bleed Easily ☐ Hives ☐ Scars
☐ Changes in Moles ☐ Itching ☐ Sores That Won't Heal
☐ Chills

Have you ever had a biopsy for a suspicious growth?

☐ Yes ☐ No

When you are exposed to the sun do you:

☐ Tan Only ☐ Tan and Burn ☐ Burn Only

Have you visited tanning salons or do you sunbathe?

☐ Yes ☐ No

Do you regularly apply sunblock to exposed areas?

☐ Yes ☐ No If yes, which SPF? _____

Have you ever had skin cancer?

☐ Yes ☐ No If yes, what type? _____

When? _____ Where? _____

## Past Medical History

Have you ever had any of the following?

☐ Alcoholism ☐ Bleeding Disorder ☐ Eating Disorder
☐ Allergies ☐ Blood Disease ☐ Epilepsy
☐ Anemia ☐ Blood Transfusion ☐ Hay Fever
☐ Anxiety Disorder ☐ Bowel Disorder ☐ Heart Disease
☐ Arthritis ☐ Cancer ☐ Heart Problems
☐ Asthma ☐ Diabetes ☐ Hepatitis - A, B, or C
☐ AIDS / HIV ☐ Depression ☐ High Blood Pressure
☐ High Cholesterol ☐ Migraines ☐ Stomach Ulcer
☐ Joint Disorder ☐ Osteoporosis ☐ Substance Abuse
☐ Kidney Disorder ☐ Pacemaker ☐ Thyroid Disorder
☐ Liver Disorder ☐ Rheumatic Fever ☐ Tuberculosis
☐ Lung Disease ☐ Sinus Problems ☐ Venereal Disease
☐ Lupus ☐ Skin Disorder
☐ Measles ☐ Stroke

## Hospitalizations & Surgeries

| Reason | Date |
|---|---|
| | |
| | |

## Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

## Family History

Has anyone in your family ever had any of the following conditions?

☐ Abnormal Moles ☐ Basal Cell Carcinoma ☐ Melanoma
☐ Acne ☐ Cancer ☐ Psoriasis
☐ Allergies ☐ Diabetes ☐ Skin Cancer
☐ Arthritis ☐ Eczema ☐ Squamous Cell Carcinoma
☐ Asthma

Details: _____

## Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

# drinks/week _____

How much caffeine do you drink per day?

# drinks/day _____

Name _____ Gender _____ Age _____

Date of Appointment: _____

## Areas of Concern or Interest

Please check any of the following areas you have questions or concerns about.

- ☐ Age Spots
- ☐ Acne
- ☐ Botox
- ☐ Chemical Peels Removal
- ☐ Dark Circles Under Eyes
- ☐ Dark Spots
- ☐ Deep wrinkles or lines
- ☐ Dry Skin
- ☐ Excessive Sweating
- ☐ Frown Lines
- ☐ Hair Removal
- ☐ Itchy Skin
- ☐ Keloids
- ☐ Laser Facial Treatment
- ☐ Leg Vein Removal
- ☐ Lip Size
- ☐ Moles
- ☐ Oily Skin
- ☐ Rosacea Treatment
- ☐ Scars
- ☐ Uneven Skin Tone

## Review of Systems

### General

- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth – Excessive
- ☐ Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst - Excessive
- ☐ Weight Gain
- ☐ Weight Loss

### Mental Health

- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Interest
- ☐ Feeling Hopeless
- ☐ Hearing Voices
- ☐ Marital Problems
- ☐ Panic Attacks
- ☐ Trouble Concentrating
- ☐ Suicide–Thoughts/Attempts

### Musculoskeletal

- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Shoulder Pain

### Gastrointestinal

- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal Disorder
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

### Genitourinary

- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination

### Respiratory

- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

### ENT

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Halos

### Cardiovascular

- ☐ Chest Pains
- ☐ Irregular Heart Beat
- ☐ Circulation Problems
- ☐ Heart Palpitations
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

### Neurological

- ☐ Coordination Problems
- ☐ Convulsions
- ☐ Difficulty Walking
- ☐ Learning Disabilities
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tremors

### Men Only

- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penile Discharge
- ☐ Sore on Penis

### Women Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge

### Other Symptoms