PATIENT REGISTRATION SLIP (PLEASE COMPLETE BOTH PAGES)

DATE:		REFERRING PHYSICIAN:
Name:		Address: City: Zip Code:
Phone Number:		Cell Number:
Birth Date:	Social Security Number:	Gender: ☐ female ☐ male
Occupation:	Employed By:	Former Occupation (if retired):
Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced		Name of Spouse or Parent/Guardian: Spouse's Occupation:
How did you hear about us? □ physician □ friend □ family □ internet □ newspaper □ phonebook		

Acknowledgment of Notice of Privacy Practices (POSTED IN WAITING ROOM) I acknowledge that a copy of this office's Notice of Privacy Practices regarding the use of health related information has been made available to me. I have had ample time to read the Notice and to ask questions related to its implementation. PATIENT (or Authorized Signature): X _____ DATE: _____

Designation of Certain Relatives, Close Friends and Other Caregivers I agree that Cosmetic & Procedural Dermatology Center, LLC may disclose certain elements of my health information to a family member, close personal friend or guardian because such a person is involved with my healthcare. In that case, Cosmetic & Procedural Dermatology Center, LLC will disclose only information that is directly relevant to that person's involvement with my healthcare or payment relating to my healthcare.

I designate the following person listed below as a person involved with my healthcare or payment related to my healthcare for the purpose of Cosmetic & Procedural Dermatology Center, LLC making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at anytime in writing. DESIGNATED PERSON (Optional): _____

Patients with Medicare:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

PATIENT (or Authorized Signature):X_____DATE: _____

HEALTH QUESTIONNAIRE

What is the primary reason you are here today?

Is there anything else we can help you with?

Current or past problems with:			If yes, please explain:
General Health	Yes ☐	No ☐	
Skin Cancer	Yes ☐	No ☐	
Ears/Nose/Throat/Mouth/Eyes	Yes ☐	No ☐	
Recurrent Sinus Infections	Yes ☐	No ☐	
Heart Disease/Heart Valve/Heart Murmur	Yes ☐	No ☐	
Hypertension	Yes ☐	No ☐	
Lungs/Kidney/Liver	Yes ☐	No ☐	
Infections including hepatitis B or C or HIV	Yes ☐	No ☐	
Arthritis/Muscles/Joints	Yes ☐	No ☐	
Psychological Disorder	Yes ☐	No ☐	
Thyroid/Diabetes	Yes ☐	No ☐	
Bleeding Tendencies	Yes ☐	No ☐	
Scarring Tendencies	Yes ☐	No ☐	
Do you have any medication allergies?	Yes ☐	No ☐	
Has any family member ever had skin cancer?	Yes ☐	No ☐	
If yes, was the cancer malignant melanoma?	Yes ☐	No ☐	
Females: Are you pregnant or planning to become pregnant?	Yes ☐	No ☐	

Have you ever been dissatisfied with the treatment you received from a doctor? □ Yes □No
If yes, please explain:

Please list any previous surgeries:

Please list any medications you are now taking:

Is there anything else we should know about your medical history?