Patient Registration Form

Date:_____

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address: Apartment:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone w/ext:	
Family Physician:	Date of Birth:	Sex: ☐ Male ☐ Female	
Marital Status:	Social Security #:		
Employer Name:	Employer Address:		
Emergency Contact:	Phone:	Relationship to Patient:	

Insurance & Payment Information

Person responsible for the bill (ONLY IF DIFFERENT THAN THE INSURED): Name:			
Date of Birth:	Social Security #:	Phone:	
Address of Person Responsible:		City/State/Zip:	
Employer of Person Responsible:		Relationship to Patient:	

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Address if not same:	Policy Holder's Address if not same:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:
Employer Name:	Employer Name:

Additional Information

Physical Address (if different than mailing):			City/State/Zip:	
Email Address:	Can we leave a message regarding your medical care & test results? ☐ Yes ☐ No			
Race (please select one):	☐ American Indian or Alaska Native	☐ Asian	☐ Black or African American	
☐ Hispanic	☐ Native Hawaiian or Pacific Islander	☐ White	☐ Other	☐ Decline
Ethnicity (please select one):	☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ Decline	
Preferred Language (please select one):	☐ English	☐ Bosnian	☐ Indian (including Hindi & Tamil)	
☐ Russian	☐ Sign Language	☐ Spanish	☐ Other	
Preferred Pharmacy Name & Location:				

FINANCIAL POLICY

I/We understand that fees for all services provided that are not covered by insurance are the patient's or insured party's obligation; and I/We further agree that if such indebtedness is placed in the hand of an attorney for collections, the undersigned will pay reasonable attorney fees and court costs. I authorize the office to submit insurance claims payable to the Tanenbaum Dermatology Center, PLC.

I authorize the release of medical information to my insurance companies, or to my attorney if liability related, or my employer and their workman's compensation carriers if a job related injury.

THE TANENBAUM DERMATOLOGY CENTER, PLC

_____

Patient's Signature

_____

Insured Party's Signature

THANK YOU

MEDICAL HISTORY

Please answer the questions below in detail. Complete information about your General Medical Condition is essential for the best Dermatological Care. Please use the back of this form for extra space.

Today's Date:_____

Past or Current Medical Conditions: _____

List Past Hospitalizations: _____

Are you pregnant? _____

What is your chief complaint? _____

When did it start? _____

What makes it worse? _____

What makes it better? _____

What medications are you presently taking (list by name/sympton, example: "Pill for High Blood Pressure")? _____

Are you taking Anticoagulant (blood thinning) Medication? (Including Aspirin) _____

Are you allergic to ANY drug taken by mouth, by injection or applied to the skin? _____

Are you allergic to ANY local anesthetic (example: Novocaine, Procaine, Xylocaine, Lidocaine)? _____

FAMILY HISTORY

Circle and list relationship if any blood relative had the following:

Melanoma	Numerous Moles	Psorasis	Eczema	Thyroid Disease	Arthritis
Severe Acne	Cancer (Internal or Skin)	Asthma	Diabetes	Polycystic Ovary Disease	Chronic Skin Disorders

Father Age_____ Health_____ Age at Death _____ Cause _____

Mother Age_____ Health_____ Age at Death _____ Cause _____

Brothers Age_____ Health_____ Age at Death _____ Cause _____

Sisters Age_____ Health_____ Age at Death _____ Cause _____

PERSONAL HISTORY (PAST HISTORY & REVIEW)

Have you, currently or in the past, had any of the following? (Circle if yes)

SKIN
Severe Teenage Acne
Sore that does not heal
Mole changing color, size, shape
Skin Cancer
When_____Where_____
When_____Where_____
Melanoma
When_____Where_____
Psoriasis
Allergic Skin Reaction
Eczema

ENT/EYES
Glacoma / Cataracts

ENT/EYES (cont.)
Frequent Sinus Infections
Frequent Throat Infections

GU
Kidney Touble
Irregular Menstrual Period
Recurrent Yeast Infections

GI
Jaundice
Diabetes
Hepatitis (Type_____)
Blood in Stools
Hemorroids
Stomach Ulcers

HEART/LUNGS
High Blood Pressure
Chest Pain / Heart Attack
Shortness of Breath
Pacemaker
Artificial Heart Valves
Heart Murmers
Rheumatic Heart Disease
Pneumonia
Hay Fever
Asthma
Tuberculosis
Chronic Cough
Emphysema

GENERAL
Weight Loss Fevers
Chicken Pox Rheumatic Fever
Swollen Lymph Nodes
Cancer (Where_____)
Blood Tranfusion (When_____)

MUSCOSKELETAL
Muscle Aches or Weakness
Arthritis
Hip / Knee Replacement

NEUROLOGY/PSYCH
Seizures Excessive Fatigue
Anxiety /Depression
Strokes

SOCIAL HISTORY

Occupation: _____ Sun-Related Activites(Circle): Golf Tennis Fishing Boating Other

Smoking: No——— Yes——— Packs per day——— Alcohol: None——— Occasional——— Daily———

Reviewed by

(MD Signature): _____ **Date** _____

THANK YOU