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PATIENT REGISTRATION FORM

MR/MRS/MS **GENDER: MALE / FEMALE**

NAME _____DATE OF BIRTH_____SSN _____

ADDRESS_____ CITY_____ STATE_____ZIP_____

MARITAL STATUS (S/M/D/W) _____ EMAIL ADDRESS _____

HOME PHONE # _____CELLPHONE#_____

FOLLOW-UP APPOINTMENT CONFIRMATION PREFERENCES: EMAIL ( ) TEXT ( ) CALL ( ) please check one

PHARMACY _____ PHARMACY PHONE # _____

EMPLOYER_____OCCUPATION_____

EMPLOYER's ADDRESS_____ WORK PHONE #_____

REFERRING PHYSICIAN_____ PHONE # _____

PHYSICIAN'S ADDRESS_____

GUARDIAN'S NAME (If patient is a minor) _____PHONE #_____

EMERGENCY CONTACT _____PHONE #_____

IF ENGLISH IS NOT YOUR PRIMARY LANGUAGE, PLEASE LIST HERE _____

ARE YOU ALLERGIC TO ANY MEDICATION/S YES_____ NO _____ IF YES, PLEASE LIST

INSURANCE INFORMATION

(*OR* PLEASE ATTACH YOUR HEALTH CARE INSURANCE CARD FOR PHOTOCOPY)

NAME OF INSURANCE _____COPAY_____

I.D. NUMBER _____ GROUP NUMBER _____

BILLING ADDRESS _____

IMPORTANT We will gladly send your invoice to the insurance company for processing. You will be notified by your insurance company whe they have processed the claim.

IT IS THE RESPONSIBILITY OF THE PATIENT TO MAKE SURE THE BALANCE OF THE ACCOUNT IS PAID WITHIN 30 DAYS

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE MY INSURANCE OR ATTORNEY TO PAY DIRECTLY TO DRS. EPSTEIN, TUFFANELLI AND NG ANY BENEFITS PAYABLE FOR SERVICES RENDERED. I ALSO AUTHORIZE T RELEASE OF ANY INFORMATION REQUIRED TO PROCESS MY CLAIM.
A COPY SHALL SERVE AS THE ORIGINAL. THIS OFFICE ABIDES BY HIPAA REGULATIONS.

X_____ _____

PATIENT'S SIGNATURE / GUARDIAN SIGNATURE (if patient is a minor) DATE

PATIENT'S INFORMATION

Name: _____ Age: _____ Gender: M / F

Reason for Visit: _____

MEDICAL HISTORY

1. Primary Care Doctor _____
2. Current Medications _____

_____

3. Medication Allergy _____
4. Medical Problems _____
5. Hospitalization Yes / No When _____ For What _____
6. Surgery Yes / No When _____ For What _____
7. Mole Removal Yes / No Any History of Skin Cancer? Yes / No
8. Sun Exposure : Do you primarily (please check) Tan _____ Burn/Tan _____ Burn only _____
9. Smoker? Yes __ No __ Alcohol? Yes ___ No ___ Quantity _____
10. Are you pregnant? Yes _____ No_____ / Considering Pregnancy? Yes _____ No _____

FAMILY MEDICAL HISTORY

Children: Yes ____ No ____ How Many _____ Health Problems _____

Siblings: How many Brother(s) _____ Sister(s) _____

Parents: Any major medical problems?
Mother _____ Father _____

Any family history of: Lots of moles yes _____ No _____
Skin Cancer Yes _____ No _____

FOR PHYSICIAN'S USE ONLY

PROBLEM LIST MEDICATIONS

DATE

_____ _____
_____ _____
_____ _____

ALLERGIES _____

_____

DOCTOR'S SIGNATURE _____