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PATIENT REGISTRATION FORM

NAME: _____ DATE OF BIRTH: _____ LAST 4 SSN: _____

ADDRESS: _____ APT#____ STATE: _____ ZIP CODE: _____

HOME PHONE#: _____ CELL PHONE#: _____

MARITAL STATUS (S/M/D/W): _____ GENDER AFFILIATION: _____

EMAIL: _____

PHARMACY: _____ PHARMACY PHONE#: _____

EMPLOYER: _____ OCCUPATION: _____

REFERRING PHYSICIAN: _____ PHONE#: _____

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 MEDICATIONS? YES____ NO____ IF YES, PLEASE LIST.

INSURANCE INFORMATION
(OR ATTACH PHOTOCOPY OF INSURANCE)

NAME OF INSURANCE: _____ COPAY: _____

SUBSCRIBER ID#: _____ GROUP#: _____

INSURANCE CLAIMS/BILLING ADDRESS: _____

IMPORTANT: We will gladly send your invoice to the insurance company for processing. You will be notified by your insurance company when 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 the release of any information required to process my claim. A copy shall serve as the original. This office abides by HIPAA regulations.

X_____ DATE: _____
PATIENT'S SIGNATURE/GUARDIAN SIGNATURE (IF MINOR)

PLEASE TURN OVER TO CONTINUE >>>>>

MEDICAL HISTORY

NAME: _____ AGE: _____ HEIGHT: _____ WEIGHT_____

REASON FOR VISIT: _____

PRIMARY CARE DOCTOR: _____

CURRENT MEDICATIONS: _____

_____

MEDICAL CONDITIONS: _____

_____

MEDICATION ALLERGIES: _____

IMMUNIZATIONS: _____

HOSPITALIZATION: YES____ NO____ WHEN: _____ FOR WHAT? _____

SURGERIES: YES____ NO____ WHEN: _____ FOR WHAT? _____

HISTORY OF MOLE REMOVAL: YES____ NO____

HISTORY OF SKIN CANCER: YES____ NO____ WHAT TYPE OF SKIN CANCER? _____

SUN EXPOSURE: DO YOU PRIMARILY..... BURN____ BURN/TAN____ TAN____

DO YOU SMOKE? YES____ NO____ DO YOU DRINK ALCOHOL: YES____ NO____

ARE YOU PREGNANT? YES____ NO____ CONSIDERING PREGNANCY?: YES____ NO____

FAMILY MEDICAL HISTORY

HISTORY OF SKIN CANCER: YES____ NO____

HISTORY OF LOTS OF MOLES: YES____ NO____

DO ANY OF YOUR PARENTS HAVE ANY MAJOR MEDICAL PROBLEMS? IF SO, PLEASE LIST.

MOTHER: _____ FATHER: _____

_____ _____

HOW MANY SIBLINGS DO YOU HAVE? _____

DO YOU HAVE CHILDREN? YES____ NO____ HOW MANY? ____ HEALTH ISSUES: _____