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PATIENT REGISTRATION FORM

GENDER: MALE/FEMALE

NAME _____ BIRTHDATE _____ SSN _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ DAY PHONE # _____

CELLPHONE # _____ EMAIL ADDRESS _____

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 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, NG AND OSHTORY** 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 _____
PATIENT'S SIGNATURE / GUARDIAN SIGNATURE (if patient is a minor)

DATE

FOR PHYSICIAN'S USE ONLY

PROBLEM LIST

MEDICATIONS

DATE

DOCTOR'S SIGNATURE _____

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 _____

8. Any History of Skin Cancer? Yes _____ No _____

9. Sun Exposure : Do you primarily (please check)
Tan _____ Burn/Tan _____ Burn only _____

10. Smoker? Yes _____ No _____

11. Alcohol? Yes _____ No _____ Quantity _____

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 _____

Doctor's Signature: _____