

PATIENT REGISTRATION INFORMATION

FIRST _____ MI _____ LAST _____ SS# _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

SEX: M _____ F _____ AGE _____ BIRTH DATE _____ MARITAL STATUS: S _____ M _____ D _____ W _____

E-MAIL ADDRESS _____ CELL _____

EMPLOYER _____ EMPLOYER PHONE _____

OCCUPATION _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

WHO REFERRED YOU TO OUR PRACTICE _____

WHAT ARE YOU BEING SEEN FOR TODAY _____

NEAREST FRIEND OR RELATIVE NOT AT THE SAME ADDRESS _____

PHONE # _____

DO YOU HAVE MEDICAL INSURANCE? YES _____ NO _____

PRIMARY INSURANCE _____ PHONE # _____ BIRTHDATE _____

INSURED NAME _____ ID # _____ GRP # _____

**PLEASE HAVE ALL INSURANCE CARDS AND DRIVERS LICENSE AVAILABLE FOR COPYING.
ALL PATIENTS PLEASE READ THE FOLLOWING DISCLOSURE AND SIGN.**

IN ORDER TO CONTROL OUR COST OF BILLING, WE REQUEST PAYMENT BE MADE AT THE TIME SERVICE IS RENDERED.

AUTHORIZATION: I HEREBY AUTHRIZE DR. PIN, FOR A PERIOD OF TEN YEARS, TO FURNISH AND/OR ELETRONICALLY TRANSMIT ANY BILLING AND/OR MEDICAL RECORD INFORMATION TO INSURANCE CARRIERS, ATTORNEYS, ANY THIRD PARTY MEDICAL RECORD RETRIEVAL SERVICE, OR ANY ENTITY NECESSARY IN THE COLLECTION OF FEES IN REGARD TO THIS ILLNESS/TREATMENT. I HEREBY IRREVOCABLY ASSIGN TO DR. PIN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

PATIENT SIGNATURE _____ DATE _____

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

PLEASE LET US KNOW IF YOU WOULD BE INTERESTED IN LEARINGING ABOUT ANY OF THE FOLLOWING PROCEDURES:

Facelift _____ Breast Lift _____ Eyelid Surgery _____ Liposuction _____ Nose Surgery _____

Tummy Tuck _____ Breast Augmentation _____ Other Cosmetic Surgery _____

MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS. IF A QUESTION DOES NOT PERTAIN TO YOUR MEDICAL HISTORY OR THE ANSWER IS NO, PLEASE MARK NO IN THE AREA PROVIDED OR MARK N/A. THANK YOU.

NAME _____ DATE _____

DATE OF LAST PHYSICAL EXAM _____ PRIMARY DOCTOR _____

OB-GYN _____

SURGERY (COSMETIC AND NON-COSMETIC)

TYPE	DATE	COMPLICATIONS OR DIFFICULTIES
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

ADMISSIONS TO HOSPITAL

REASON	DATE	COMPLICATIONS OR DIFFICULTIES
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

MEDICATIONS (ANY DRUG OR MEDICINE) YOU TAKE NOW

TYPE	DOSAGE	HOW OFTEN TAKEN
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

CONSUMPTION OF THE FOLLOWING

ASPIRIN _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____
 ALCOHOL _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____
 TOBACCO _____ AMOUNT DAILY _____ AMOUNT WEEKLY _____

HERBAL SUPPLEMENTS YES ___ NO ___ LIST _____

VITAMINS YES ___ NO ___ LIST _____

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY? YES ___ NO ___

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? YES ___ NO ___

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA? YES ___ NO ___ EXPLAIN _____

MEDICAL PROBLEMS OR CONDITIONS NOW UNDER TREATMENT BY A PHYSICIAN _____

HAVE YOU EVER BEEN EXPOSED TO

YES _____ NO _____ INTRAVENOUS DRUGS
YES _____ NO _____ INFECTIOUS DISEASES
YES _____ NO _____ TB
YES _____ NO _____ AIDS
YES _____ NO _____ HEPATITIS

HISTORY OF EPILEPSY OR MENTAL ILLNESS? YES _____ NO _____ EXPLAIN _____

CHILDHOOD MEDICAL HISTORY

HAD ALL KNOWN "BABY SHOTS" YES _____ NO _____ UNCERTAIN _____
HAD POLIO IMMUNIZATION YES _____ NO _____ UNCERTAIN _____
HAD RHEUMATIC FEVER YES _____ NO _____ UNCERTAIN _____

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESSES? YES _____ NO _____

MOTHER _____ FATHER _____

SISTER _____ BROTHER _____

REVIEW OF SYSTEMS

ANY SIGNIFICANT MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING? (Mark all that are applicable)

- ____ HEAD; IF YES EXPLAIN:
- ____ EYES; IF YES EXPLAIN:
- ____ EARS, NOSE, THROAT; IF YES EXPLAIN:
- ____ THYROID; IF YES EXPLAIN:
- ____ LUNGS; IF YES EXPLAIN:
- ____ HEART; IF YES EXPLAIN:
- ____ BLOOD PRESSURE OR VESSELS; IF YES EXPLAIN:
- ____ DIGESTIVE SYSTEMS; IF YES EXPLAIN:
- ____ LIVER; IF YES EXPLAIN:
- ____ MUSCLES, BONES; IF YES EXPLAIN:
- ____ REPRODUCTIVE ORGANS; IF YES EXPLAIN:
- ____ KIDNEYS, BLADDER; IF YES EXPLAIN:
- ____ UNSIGHTLY SCARS; IF YES EXPLAIN:
- ____ DISEASE AFFECTING IMMUNE SYSTEM; IF YES EXPLAIN:
- ____ URINARY INCONTINENCE:
- ____ OTHER; IF YES EXPLAIN:

WOULD YOU LIKE A REFERRAL FOR ANY OF THESE PROBLEMS? YES _____ NO _____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES _____ NO _____ PLEASE LIST _____

ARE YOU PREGNANT? YES _____ NO _____

PREGNANCY HISTORY _____