PATIENT REGISTRATION INFORMATION

FIRST_____MI_____LAST_____SS#_____

ADDRESS_____PHONE_____

CITY_____STATE_____ZIP_____

SEX: M_____F_____ AGE_____ BIRTH DATE_____ MARITAL STATUS: S_____M_____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 _____