Patient Registration Form

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Phone/text/fax 202-838-3016

Date:	**MRN No:**

DEMOGRAPHIC INFORMATION

First Name:	**Last Name:**	**MI:**
DOB:	**SSN:**	**Age:**
Marital Status: (Circle One) **Married** **Single** **Widow** **Divorced**		**Sex:**
Address:	**City:**	**State:**
Apt/Unit	**Zip Code:**	**Country:**
Race: (Circle One) African American/Black Caucasian/White Asian American Indian/Alaskan Native Nat Hawaiian/Pacific Islander Other Unknown Declined		
Ethnicity: (Circle One) Hispanic or Latino Not Hispanic or Latino Unknown Declined		

CONTACT INFORMATION

Enter and Place a check in the box your primary phone number:	**Cell:** ☐	**Home:** ☐	**Work:** ☐
Email Address:			
Employer:		**City, State:**	
EMERGENCY CONTACT INFORMATION			
Name:	**Relationship:**	**DOB:**	**Phone:**

PHARMACY AND PROVIDER INFORMATION:

Preferred Pharmacy:	**Pharmacy Phone:**
Pharmacy Address:	
Referred Physician:	**Primary Care Physician:**

How did you hear about us? **(Circle One)** Physician Family/Friend Health Plan Website/Internet Seminar/Lecture Student Health ER Other

INSURANCE/BILLING INFORMATION:

Primary Insurance	
First Name:	**Last Name:**
Primary Ins:	**Policy ID#**
Policy Holder:	**Group #:**
Relationship to Policy Holder:	
If patient is not policy holder, what is the holder's DOB? mm/dd/yyyy	**Address?** **(**If not the same as patient**)**

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Name:	**Date:**	**MRN No:**

Secondary Insurance	
First Name:	**Last Name:**
Primary Ins:	**Policy ID#**
Policy Holder:	**Group #:**
Relationship to Policy Holder	
If patient is not policy holder, what is the holder's DOB? mm/dd/yyyy	**Address?** (If not the same as patient)

Current Issue(s):

PAST MEDICAL HISTORY (Circle all that apply currently or in the past)

Anxiety	Depression	Keloids
Abnormal Scarring	Diabetes	Leukemia
Arthritis	Difficulty Healing Wounds	Lung Cancer
Asthma	End Stage Renal Disease	Lung Disease
Artificial Heart Valve	Fever Blisters	Lymphoma
Artificial Joints	GERD	Migraines
Atrial Fibrillation	Hearing Loss	Neuralgia
Back or Neck problems	Heart Disease	Pacemaker/Defibrillator
Bone Marrow Transplantation	Hepatitis B or C/ Liver Disease	Prostate Cancer
Breast Cancer	High Blood Pressure	Radiation Treatment
Blood Clotting Disorders	High Cholesterol	Seizures
Colon Cancer	HIV/AIDS	Skin Cancer
COPD	HSV (Herpes Type I or Type II)	Stroke/ Heart Attack
Coronary Artery Disease	Kidney Disease	Thyroid Disorder
Other:		

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PAST DERMATOLOGIC HISTORY (Circle all that apply currently or in the past)

Acne	Dry Skin	Osteoporosis
Actinic Keratoses	Eczema	Poison Ivy
B-Cell Lymphoma	Flaking or Itchy Scalp	Precancerous Moles
Basal Cell Skin Cancer	Hair loss	Psoriasis
Blistering Sunburns	Hay Fever/ Allergies	Seasonal Allergies
Contact Dermatitis	HPV	Squamous Cell Skin Cancer
Cyst	Leiomyosarcoma	Warts
Dermatitis	Melanoma	
Other:		

ALERTS (Circle all that apply)

Allergy to Adhesive	Defibrillator
Allergy to Lidocaine	MRSA
Allergy to Topical Antibiotics	Pacemaker
Artificial Heart Valve	Required antibiotics prior to surgical procedure
Artificial Joint Replacement	Rapid heartbeat with epinephrine
Blood Thinners	Are your Pregnant?
Other:	

PAST SURGICAL HISTORY (Please list all past surgeries or Procedure)

Date	Procedures	Complications

PAST DERMATOLOGIC PROCEDURES: (Please list all past cosmetic or non-cosmetic procedures)

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MEDICATIONS/SUPPLEMENTS (Please list all current and/or supplements

Medication/Supplement	Dosage	Indication (Why are you taking this medication?)

ALLERGIES: (Please list all allergies, including medications, latex and/or foods) **If none, please check here: □ NKDA**

_____

_____

FAMILY HISTORY: (Is there a Family History of the following? Please note relationship and age of relative)

_____

_____

SOCIAL HISTORY:

Smoker?	Currently / Former / Never If currently, how many cigarettes per day?____
Do you drink alcohol?	Y / N If Yes, how much_____per week?
Do you use recreational drugs?	Y / N If Yes, which ones and how often?
Do you feel safe at home?	Y / N
What is your relationship status?	Single / Dating / Engaged / Married / Divorced / Widowed

OTHER MEDICAL ISSUES WE SHOULD BE AWARE OF:

_____

_____