PATIENT REGISTRATION FORM

Today's Date: _____/_____/______

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss.

Name: ____ ☐ Jr. ☐ Sr.
First Middle Last

Address: ____
Number Street Name Apt. Number City State Zip

Social Security Number (required for insurance claims):______-_______-_________ Sex: ☐ M ☐ F

Employer: ____
Name Address

Primary Phone #: ____________________ ☐ Home ☐ Work ☐ Cell Date of Birth: _____/______/_____

Secondary Phone#: __________________ ☐ Home ☐ Work ☐ Cell

Tertiary Phone#: ____________________ ☐ Home ☐ Work ☐ Cell

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Name of Spouse or Significant Other: ____

Parent or Responsible Party (Guarantor) (Fill this information if you are not the primary on the insurance card)

Name: ____ ☐ Jr. ☐ Sr.
First Middle Last

Address: ____
Number Street Name Apt. Number City State Zip

Employer: ____
Name Address

Home Phone: __________________ Work Phone:______________ Date of Birth ____/______/____

Social Security Number (required for insurance claims): ______-______-_______ Sex: ☐ M ☐ F

If Student: ☐ Full Time ☐ Part Time Name of School:_______________________________

Please present all insurance cards and photo ID to the receptionist so copies may be made.

In case of emergency, who should be notified: ______________________________________ Phone_________________

Referring Physician: _______________________________ Primary Care Physician: ____________________________

I authorize the release of medical information to my primary care or referring physician, to consultant if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I authorize payment of medical benefits to physicians. I have received a copy of the HIPAA regulations or Notice of Privacy Practices:

In order to establish optimal relations with out patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE. For insured patients, applicable co-payments and deductibles will be collected. Insurance coverage can be pre-verified, and you will be asked to pay any unmet deductible, non-covered services, and co-payments. However, the EOB (explanations of benefits) form of your insurance may show un-paid deductibles and co-payments and you will be billed for those charges that are your responsibility according to the terms of your policy. In the event that your account must be turned over to collections, a $10 collection fee will be added to your account. A returned check will incur a $25 processing penalty from this office. Your signature below indicates that you understand and accept this policy.

Patient or Responsible Party Signature (required)_______________________________Date:____/______/____

Nelson Charlie, M.D. Dermatology

Patient Name: ______________________________ **Date of Birth:** _______________ **Today's Date** ___________

List all Allergies: (*Write NONE, if none*)____

List all Current Medications: (*Write NONE, if none*) ____

____

Reason for Today's Visit: (*include duration of problem and previous treatments*)___________________________________
____
____

Any Past Skin Problems: ☐skin cancer, not melanoma ☐**melanoma** ☐childhood blistering sunburns ☐psoriasis ☐eczema:
Details:____
____

Current or Past Problems with:

	YES	NO	Explain if **YES**
General Health	☐	☐	__________________________
Eyes	☐	☐	__________________________
Ears/Nose/Throat/Mouth	☐	☐	__________________________
Heart	☐	☐	__________________________
Lungs	☐	☐	__________________________
Stomach/Bowels	☐	☐	__________________________
Kidneys	☐	☐	__________________________
Arthritis/Muscles/Joints	☐	☐	__________________________
Headaches/Seizures	☐	☐	__________________________
Psychological Disorder	☐	☐	__________________________
Thyroid/Diabetes	☐	☐	__________________________
Blood/Bleeding Disorder	☐	☐	__________________________
Allergic/Immunologic	☐	☐	__________________________
HIV+/Hepatitis B or C	☐	☐	__________________________
Transplants/Implants	☐	☐	__________________________

List All Surgeries and Operations

Write NONE, if none ___________

Females: ●Are you pregnant? ☐Yes ☐No ●Planning to become pregnant? ☐Yes ☐No ●Nursing? ☐Yes ☐No

Family History: (Past Family and Social History)

●Mother: living or deceased of ___________ at age ______ ●Father: living or deceased of _________ at age _______

●Number of your children: _________________ age(s) ____________________________

Check the following medical conditions that have occurred in your family:

DISEASE	**Mother**	**Father**	**Blood Relative**
Allergies/hayfever/asthma	☐	☐	☐
Arthritis	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Eczema	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Malignant Melanoma	☐	☐	☐
Psoriasis	☐	☐	☐
Skin cancer	☐	☐	☐
Tuberculosis	☐	☐	☐

Social History

✓ Do you use sunscreens? ☐No ☐Daily ☐Sometimes

✓ Do you smoke? ☐No ☐Yes Packs/day_________

✓ Do you drink alcohol? ☐No ☐Yes ☐Socially

✓ Hobbies & Leisures__________________________
____

✓ Occupation ______________________________

Reviewed ________________________________ **Date** ______________
(MD signature)