SOUTHEASTERN DERMATOLOGY

PATIENT REGISTRATION FORM

NAME: ______________________________ SOCIAL SECURITY NUMBER: ________________

DATE OF BIRTH: ___/___/____ MARRIED/SINGLE/DIVORCED/WIDOWED (CIRCLE)

SEX: M / F OCCUPATION: _________________________________

E-MAIL ADDRESS: ___________________________ PRIMARY CARE PHYSICIAN: _______________________

HOME ADDRESS: ____________________________ CITY/STATE/ZIP: _______________________________

HOME PHONE: ( )_________ WORK PHONE: ( )_________ CELL PHONE: ( )_________

EMERGENCY CONTACT: _________________________________ PHONE: ____________________________

HOW DID YOU HEAR ABOUT OUR OFFICE? (PLEASE CHECK ALL THAT APPLY)

___FRIEND ___RELATIVE ___PHYSICIAN ___NEWSPAPER ___MAGAZINE ___OTHER__________________

DID A HEALTH CARE PROVIDER REFER YOU TO OUR OFFICE? ___YES ___NO
IF YES, PLEASE NAME: ____

ACCOUNT GUARANTOR (IF DIFFERENT FROM ABOVE)

NAME: _________________________________ SOCIAL SECURITY NUMBER: _________________

DATE OF BIRTH: ___/___/____ RELATIONSHIP: ___SPOUSE ___PARENT __OTHER

ADDRESS: ________________________________ CITY/STATE/ZIP: ___________________________

HOME PHONE: ( )_________ WORK PHONE: ( )_________ CELL PHONE: ( )_________

BRIEF MEDICAL/SOCIAL HISTORY

CURRENT MEDICATIONS: ____

ALLERGIES AND/OR REACTIONS TO MEDICATIONS: ____

GENERAL HEALTH: (CIRCLE ONE) EXCELLENT/GOOD/FAIR/POOR

DO YOU DRINK ALCOHOL? ___YES ___NO IF YES, ____ PER WEEK DO YOU SMOKE: ___YES ___NO

HAS ANY CLOSE RELATIVE HAD A DIAGNOSIS OF: (CIRCLE ALL THAT APPLY)
MELANOMA OTHER SKIN CANCER ASTHMA HAY FEVER ECZEMA LUPUS PSORIASIS

PREFERRED PHARMACY: ___________________________________ PHONE: _______________________

DURING YOUR VISIT TODAY OR ON FUTURE VISITS IT MAY BE NECESSARY FOR YOU TO HAVE A SKIN BIOPSY, CRYO-THERAPY (LIQUID NITROGEN) OR OTHER MINOR PROCEDURES FOR THE TREATMENT OF YOUR SKIN CONDITION. POTENTIAL RISKS INCLUDE SCARRING, BLEEDING, AND INFECTION. PLEASE INDICATE BY SIGNING BELOW THAT YOU UNDERSTAND AND CONSENT TO THESE TREATMENTS (IF NECESSARY).

SIGNATURE: ______________________________ DATE: ____________________________

ALL CO-PAYS, CO-INSURANCE, AND/OR DEDUCTIBLES AND PAST DUE BALANCES MUST BE PAID AT THE TIME OF YOUR APPOINTMENT