PATIENT REGISTRATION

NAME _____ DATE _____/_____/_____

SEX □ MALE □ FEMALE AGE _____ BIRTHDATE _____/_____/____ MARITAL STATUS S M W D

LOCAL ADDRESS_____

PERMANENT ADDRESS _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ E-MAIL _____

SS# _____ DRIVERS LICENSE # _____

EMPLOYER _____ EMPLOYER PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

INSURANCE COVERAGE – PRIMARY

INSURANCE COMPANY _____ POLICY # _____ GROUP # _____

NAME OF POLICY HOLDER (INSURED) _____ BIRTHDATE _____/_____/_____ (POLICY HOLDER)

POLICY HOLDER'S RELATIONSHIP TO INSURED □ MOTHER □FATHER □ SPOUSE

INSURANCE COVERAGE – SECONDARY

INSURANCE COMPANY _____ POLICY # _____ GROUP # _____

NAME OF POLICY HOLDER (INSURED) _____ BIRTHDATE _____/_____/_____ (POLICY HOLDER)

POLICY HOLDER'S RELATIONSHIP TO INSURED □ MOTHER □FATHER □ SPOUSE

PATIENT OR PARENT/GUARDIAN SIGNATURE _____ DATE _____/_____/_____

Patient Communication Form

It is the office policy of Debra Price MD PA not to release confidential medical information regarding your treatment to family members or friends, except for a parent/legal guardian, other persons authorized by the patient, or as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), in emergency situations, or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

If you anticipate that you will need or want your medical information to be provided to family members, friends or caretakers/babysitters, please indicate that below. If you do not want any of your medical information provided to a family member, please check the box next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (**If you wish to add names in the future, you may do so in writing).**

☐ I authorize my protected health information to be disclosed to the following:

Spouse _____

Parent_____

Other _____
Relationship

Other_____
Relationship

☐ I **do not** authorize my protected health information to be disclosed to anyone other than myself.

_____
Patient Name (Print)

_____ ____/____/____
Patient or Parent/Legal Guardian Signature Date

Pharmacy Information

Insurance ☐ Medicare ☐ Other _____
Insurance Plan

Preferred Pharmacy _____

Address _____
Street

_____
City State Zip Code

Telephone Number _____

Alternative Pharmacy _____

Address _____
Street

_____
City State Zip Code

Telephone Number _____

HEALTH QUESTIONNAIRE

Patient Name _____ Age _____ Date _____ /_____ /_____

Reason for Visit _____

Current or Past Medical Conditions

- □ Allergic Rhinitis (Hay Fever)
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation
- □ Bipolar Disorder
- □ Blood Clotting Disorder
- □ Breast Cancer
- □ Colon Cancer
- □ Cataract
- □ Colitis
- □ Coronary Heart Disease
- □ Congestive Heart Failure
- □ Depression
- □ Diabetes
- □ Elevated Cholesterol
- □ Gastritis
- □ Glaucoma
- □ Genital Herpes
- □ Hepatitis B
- □ Hepatitis C
- □ Hearing Loss
- □ Heart Attack
- □ Heart Valve Disease
- □ Heart Valve Replacement
- □ Hypertension
- □ Hyperthyroidism
- □ Hypothyroidism
- □ HIV or AIDS
- □ Irritable Bowel
- □ Kidney Disease
- □ Liver Disease
- □ Lupus
- □ Migraines
- □ Mitral Valve Prolapse
- □ Multiple Sclerosis
- □ Osteopenia
- □ Osteoporosis
- □ Peptic Ulcer Disease
- □ Pace Maker or Defibrillator
- □ Prostate Cancer
- □ Pulmonary Embolism
- □ Prosthetic Joint or Implant
- □ Seizure
- □ Stroke
- □ Tuberculosis
- □ Varicose Veins
- □ Weight Loss (Intentional)
- □ Weight Loss (Unexplained)
- ☐ Other _____

Dermatology History

- □ Abnormal Moles
- □ Acne
- □ Actinic Keratosis
- □ Eczema
- □ Herpes or Cold Sores
- □ Hyperpigmentation
- □ Increased Hair Growth
- □ Hair Loss
- □ Melanoma
- □ Nail Problem
- □ Psoriasis
- □ Shingles
- □ Thick Scars or Keloids
- □ Skin Cancer
- □ Other_____

Family History

Arthritis	☐Mother	☐ Father	☐Blood Relative
Asthma	☐Mother	☐ Father	☐Blood Relative
Depression	☐Mother	☐ Father	☐Blood Relative
Diabetes	☐Mother	☐ Father	☐Blood Relative
Breast Cancer	☐Mother	☐ Father	☐Blood Relative
Heart Disease	☐Mother	☐ Father	☐Blood Relative
Thyroid Disease	☐Mother	☐ Father	☐Blood Relative
Other	☐Mother	☐ Father	☐Blood Relative

Family History of Skin Disease

Abnormal Moles	☐Mother	☐ Father	☐Blood Relative
Acne	☐Mother	☐ Father	☐Blood Relative
Eczema or Dermatitis	☐Mother	☐ Father	☐Blood Relative
Melanoma	☐Mother	☐ Father	☐Blood Relative
Skin Cancer	☐Mother	☐ Father	☐Blood Relative
Psoriasis	☐Mother	☐ Father	☐Blood Relative
Thick Scars or Keloids	☐Mother	☐ Father	☐Blood Relative

Immunizations

☐ Pneumococcal Vaccine ☐ Tetanus Vaccine ☐ Influenza Vaccine ☐ Shingles Vaccine

Social History

Sunscreen Usage ☐ Daily ☐ Occasionally ☐ Never

Alcohol Use ☐ Yes ☐ Social ☐ Daily ☐ Beer ☐ Wine ☐ Liquor
☐ Never ☐ Ex- Drinker

Illicit Drug Use ☐ Yes ☐ Recreational Drug Use ☐ Ex-Drug Use ☐ Never

Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Smoking Status ☐ Current Smoker ☐ Light ☐ Moderate ☐ Heavy ☐ Occasional
☐ Former Smoker ☐ Never Smoked ☐ Cigar Smoker

Surgeries and/or Hospitalizations

Hospitalizations_____

Cosmetic Surgeries _____
Cosmetic Procedures
- ☐ Filler Injections _____
- ☐ Botox ☐ Dysport ☐ Xeomin ☐ Laser ☐ Peels
- ☐ Other _____

Other Surgeries _____

Current Medications _____

Vitamins and Herbal Supplements _____

Allergies ☐ Medications _____

☐ Latex ☐ Anesthetics _____

Females Only

☐ Dysmenorrhea ☐ Polycystic Ovarian Disease ☐ Not Pregnant
☐ Endometriosis ☐ Menopausal Symptoms ☐ Pregnant
☐ Infertility ☐ Postmenopausal
☐ Irregular Periods ☐ Breastfeeding
☐ Planning to Become Pregnant No Yes When? _____
☐ Date of Last Menstrual Period ____ /____ /____ ☐ N/A

Patient Signature _____ **Date** _____ /_____/_____

PLEASE ☑ IF YOU ARE INTERESTED IN INFORMATION ABOUT:

☐ Skin Care for Acne, Hyperpigmentation or Aged Skin

☐ Diet and Acne

☐ Sun Safety and Sunscreens

☐ Skin Cancer Prevention

☐ Skin Rejuvenation

☐ Lip Enhancement

☐ Filler Injections

☐ Kybella Injections for Double Chin

☐ Botox Injections

☐ Skin Tightening

☐ Laser Hair Removal

☐ Laser Treatment of....

- ☐Brown Spots, Sun Spots or Freckles
- ☐Blood Vessels
- ☐Wrinkles
- ☐Tattoos
- ☐Acne Scars

☐ Facials

☐ Peels

☐ Visia Complexion Analysis

☐ UltraShape Non-Surgical Fat Reduction

☐ Cellulite Treatment