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

☐ Other ____

Dermatology History

Abnormal Moles	Hyperpigmentation	Psoriasis
Acne	Increased Hair Growth	Shingles
Actinic Keratosis	Hair Loss	Thick Scars or Keloids
Eczema	Melanoma	Skin Cancer
Herpes or Cold Sores	Nail Problem	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
Endometriosis
Infertility
Irregular Periods

Polycystic Ovarian Disease
Menopausal Symptoms
Postmenopausal
Breastfeeding

Not Pregnant
Pregnant

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