

PATIENT REGISTRATION

Patient Name _____ Social Security No. _____
Street Address _____ Date of Birth _____ Marital Status: S M W SEP D
City / State _____ Zip Code _____
Email Address _____
Tel:(day) _____ (eve.) _____

PATIENT EMPLOYER INFORMA-

Employer Name _____ Tel. _____
May we leave a message: Y N
Employer Street Address _____ City / State _____ Zip Code _____
Patient's Occupation _____

INSURED PERSON (IF NOT PATIENT)

Name _____ Date of Birth _____ Tel. _____
Street Address _____ City / State _____ Zip Code _____

INSURED PERSON EMPLOYER INFORMATION

Employer Name _____ Tel. _____
Employer Street Address _____ City / State _____ Zip Code _____

INSURANCE

1	Primary Insurance Co. Name	ID No.	Plan	Group
	Subscriber's Name	Relationship		
2	Secondary Insurance Co. Name	ID No.	Plan	Group
	Subscriber's Name	Relationship	Subscriber's Employer	

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Date _____ Signature _____

I hereby authorize Pinski Dermatology Cosmetic Surgery to apply for benefits on my behalf for covered services rendered by him / her, or his / her order. I request that payment from my insurance company be made directly to Pinski Dermatology Cosmetic Surgery (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked either by me or by my insurance company at any time in writing.

Date _____ Signature _____

HISTORY AND PHYSICAL

Name _____ Tel: (Day) _____ (Eve.) _____
Social Security No. _____ Date of Birth _____ Referred By: _____

HISTORY OF PRESENT ILLNESS

PAST MEDICAL HISTORY

Medical: _____	Surgical: _____
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS

Stool Softeners: _____
Vitamins _____
Sleeping Pills _____
Contraceptives _____
Tranquilizers _____
Analgesics _____
Diuretics _____
Other _____

DRUG ALLERGIES / ALLERGIES

FAMILY HISTORY

Diabetes _____
Heart Disease _____
High Blood Pressure _____
Anemia/Bleeding _____

SOCIAL HISTORY

Occupation _____
Smoker _____
Alcohol _____
Pets _____
Children: Number: _____ Ages: _____
Problems: _____