EDWARD E. ASTON IV, M.D., INC.
WILLIAM P. BAUGH, M.D., INC.

PATIENT REGISTRATION RECORD

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Date ______________________

Patient Name ____
First Name Middle Initial Last Name

Mr./Mrs./Ms./Miss
Circle One

Married/Single
Circle One

Spouse's Name ______________________

SS# ______________ **Date of Birth** ______________ **Age** ______________

Home Phone ______________________ **Cell Phone** ______________________

Address ____
Street City Zip

Parent Name ____
if pt is a minor

Email Address ____

Employer ______________________ **Phone** ______________________

Employer Address ____

Insurance Co ______________ **Subscriber** ______________ **DOB** ______________

Secondary Insurance ______________ **Subscriber** ______________ **DOB** ______________

Family Physician ______________ **Pharmacy** ______________________
(name/location)

How Did You Hear of Us? ______________________________

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize Edward E. Aston IV, M.D., Inc. and William P. Baugh, M.D. Inc. to furnish information to insurance companies concerning this illness and I hereby irrevocably assign to my physician all payments for services rendered. I understand that I am responsible for any balance not paid by my insurance company.

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DERMATOLOGY HISTORY CHECKLIST

PATIENT NAME____DATE_______________

LIST ANY MAJOR ILLNESS ____

LIST SURGERIES ____

DO YOU HAVE A HISTORY OF: (circle yes or no)

HYPERTENSION (HIGH BLOOD PRESSURE) **yes/no** DIABETES **yes/no**
HEART DISEASE **yes/no**

DO YOU HAVE A PROSTHETIC DEVICE? **yes/no**
(PACE MAKER, HIP OR KNEE REPLACEMENT, HEART VALVE)

LIST ALL MEDICATION (INCLUDING ASPIRIN, LAXATIVES, VITAMINS & OVER-THE-COUNTERS MEDS) YOU TAKE

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? **yes/no**

if yes, please list ____

DO YOU HAVE ANY FOOD ALLERGIES? **yes/no**

if yes, please list ____

DO YOU HAVE ANY ENVIRONMENTAL ALLERGIES? **yes/no**

if yes, please list ____

DO YOU OR A FAMILY MEMBER HAVE A HISTORY OF ASTHMA OR HAYFEVER? **yes/no**

DO YOU GET A LOT OF SUN EXPOSURE, OR HAVE YOU HAD A LOT OF SUN EXPOSURE IN THE PAST? **yes/no**

HAVE YOU EVER HAD SKIN CANCER? **yes/no**

DO ANY FAMILY MEMBERS HAVE A HISTORY OF SKIN CANCER? **yes/no**

DO ANY FAMILY MEMBERS HAVE A HISTORY OF MELANOMA? **yes/no**

HAVE YOU EVERY HAD X-RAY TREATMENT FOR ACNE , THYROID, ETC? **yes/no**

WHEN YOU ARE EXPOSED TO SUNLIGHT DO YOU…

BURN __________ BURN THEN TAN__________ TAN ONLY__________