REED & FISHER DERMATOLOGY **Patient Registration Sheet**

PATIENT

Last Name: ____________________________ First Name: ____________________________ M.I. ________

Mailing Address: ____

City: ____________________________________ State: __________________ Zip Code: _______________

Home Phone: (____)_______________ Daytime #: (____)_______________ Cell #: (____)_______________

Sex: **M** **F** Marital Status: **S** **M** **D** **W**

Date of Birth: _________________________ Social Security Number: ______________________________

Employer: ____ Telephone: (____)_______________

Address: ____

City: ____________________________________ State: __________________ Zip Code: _______________

INSURANCE Primary Insurance: ____

Address: ____________________________ City: _________________ State: ______ Zip Code: _________

Phone: (____)_______________ Policy Holder: _______________________ Policy #: _________________

Secondary Insurance: ____

Address: ____________________________ City: _________________ State: ______ Zip Code: _________

Phone: (____)_______________ Policy Holder: _______________________ Policy #: _________________

Spouse/Parent/Guardian: ____________________________ Social Security #: ______________________

For Parents Only: Father's Date of Birth ________________ Mother's Date of Birth ________________

Employer: ____ Telephone: (____)__________________

Nearest Relative NOT living with you ____

Relationship _______________________________________ Telephone: (____)__________________

Referred by: ____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: I understand that I am responsible for all medical expenses regardless of insurance coverage. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize REED & FISHER DERMATOLOGY to release any information acquired in the course of my examination or treatment to insurance carriers, attorneys or agencies involved in the payment of my account.
ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits directly to REED & FISHER DERMATOLOGY.

____ ______________________________

Signature of Patient, Parent, or Legal Guardian Date

PARENTS OF MINOR PATIENTS, 18 YEARS AND UNDER – Please sign and date this authorization.
I hereby authorize REED & FISHER DERMATOLOGY to treat my child who is under the age of 18 years. My signature grants permission for any procedures deemed necessary, and any follow up treatments.

____ ______________________________

Signature of Patient, Parent, or Legal Guardian Date

REED & FISHER DERMATOLOGY

Medical Information

Date: __________ Name: ____ Age: _________
(First) (Middle) (Last)

Reason for Visit: ____

____

Have **YOU** ever had a skin cancer of any type? No Yes (circle one)

If yes, was it: Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma (circle one)

Where were they located? ____

Do **YOU** have a history of other specific skin diseases? No Yes (circle one)

If yes, please list: ____

Who is your Family Doctor?____

ALLERGIC TO: _________ Penicillin __________ Sulfa __________ No Known Allergies

Other: ____

Please explain type of reaction that occurs with these allergies: ______________________

____

List all medications currently taking:

1. ____________________________________ 2. ____________________________________
3. ____________________________________ 4. ____________________________________

Do **YOU** have, or have you had any of the following medical problems?

Diabetes	No	Yes	Heart Valve Replacement	No	Yes
High Blood Pressure	No	Yes	Joint Replacement	No	Yes
Glaucoma	No	Yes	Cancer	No	Yes
Heart Disease	No	Yes	HIV/AIDS	No	Yes
Heart Surgery	No	Yes	Tuberculosis/+PPD	No	Yes
Pacemaker	No	Yes	Liver Disease/Hepatitis	No	Yes
Thyroid Disease	No	Yes	Kidney Disease	No	Yes
Asthma/Hayfever	No	Yes	Severe Scarring	No	Yes
Bleeding Disorder	No	Yes	Do You Smoke?	No	Yes
Allergy to Local Anesthetic	No	Yes	Fainting?	No	Yes
Arthritis	No	Yes			

Please list any other significant health problems we should know about: __________________

____

Family History: Have any of your immediate family members had skin cancer? No Yes

If yes, who ____

For Females Of Child-Bearing Age:

Are you currently pregnant, trying to conceive or breast-feeding? No Yes

Method of birth control presently using? (please circle one) Birth Control Pills Tubal Ligation

Hysterectomy Spouse Vasectomy Abstinence Other ______________________

Social History: What is your occupation? ____

What are your hobbies? ____

Reviewed and signed by Physician ____________________________________ Date ___________

REED & FISHER DERMATOLOGY
ACKNOWLEDGEMENT OF RECEIPT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices.

By signing this form, you agree that you have had the opportunity to read our Notice of Privacy Practices.

I have received a copy of the Notice of Privacy Practices for Reed & Fisher Dermatology.

____
Patient Name (Please Print)

______________________________________ __________________________
Signature of Patient (or patient's representative) Date