PATIENT REGISTRATION FORM: (PLEASE PRINT) DATE:_____

Name:_____
Last First Initial

Mailing Address:_____
Street City State Zip

Home Phone:_____Cell:_____Work_____

Birthdate:_____Age:_____Social Security #_____

Marital Status: S M W D Sep Employer:_____Occupation_____

Insurance #1:_____ ID #_____Grp#_____

Insurance #2:_____ ID #_____Grp#_____

Spouses Name: _____Birthdate:_____

Spouses Employer:_____

Ask our staff how you can receive our quarterly Newsletter via email

Reason for visit:_____

Have you consulted with other doctors for this: Y N If yes who?_____

Primary care doctor:_____Last visit_____

Emergency Contact :_____Phone_____

How did you here about our office?_____

MEDICAL HEALTH HISTORY Age:____Weight:_____Height:_____

Anticoagulants (blood thinner)	Y	N	AIDS, HIV+ or Hepatitis	Y	N
Arthritis or Rheumatism	Y	N	Nervous breakdown	Y	N

Asthma	Y	N	Psychotherapy	Y	N
Hay fever or Allergies	Y	N	Alcoholism	Y	N
Chest pains	Y	N	Drug addiction	Y	N
Diabetes	Y	N	Epilepsy	Y	N
High blood pressure	Y	N	Prostate trouble	Y	N
Glaucoma	Y	N	Kidney disease	Y	N
Medical radiation treatment	Y	N	Rheumatic fever	Y	N
Shortness of breathe	Y	N	Stomach ulcers	Y	N
Ankle swelling	Y	N	Tuberculosis	Y	N
Venereal disease	Y	N	Often exhausted or fatigued	Y	N
Allergic to tape	Y	N	Allergic to latex / rubber	Y	N
Keloid / thick scars	Y	N	Allergic to dental anesthetic	Y	N
Do you bruise easy	Y	N	Abnormal bleeding problems	Y	N
Often unhappy / depressed	Y	N	History of blood transfusion	Y	N
Take antidepressant meds.	Y	N	Possibly Pregnant	Y	N
Allergic to surgical tape	Y	N	Do you heal well	Y	N
Taking nerve medications	Y	N	Taking sleep medications	Y	N

Any serious illness not listed:_____

Do you smoke?_____ How much per day ?_____For how long ?_____

Do you smoke or have you ever smoked marijuana or used recreational drugs? Y N

Mental health disorder(s):_____Treating doctor:_____

Do you regularly drink alcohol? _____How much per week?_____

Can you climb 2 flights of stairs without being out of breath? Y N

Any known drug allergies:_____

MEDICATIONS:_____

_____

SURGERIES AND DATES: _____

_____

Plastic Surgeries/dates:_____