

REGISTRATION FORM

Today's date: _____ Primary Doctor: _____

PATIENT INFORMATION

Patient's last name: (Line below) _____ First: _____ Middle: _____ Date of Birth: _____ Marital status (circle one)
 - - Single / Mar / Div / Sep / Wid

Street address: (Line below) _____ City: _____ State: _____ Zip Code: _____

Home Phone no: _____ Social Security no. of patient: _____ Age: _____ Sex: M F Spouse's name (if applicable): _____

Cell Phone no: _____ Employer: _____ Occupation: _____ Employer phone no.: _____

Referred to clinic by (please check one box): Family/ Friend Internet Insurance Plan
 Dr. Mailer/Advertisement Yellow pages Other

INSURANCE INFORMATION

Subscriber's name: (policy holder) _____ Subscriber's S.S # _____ Birth Date _____ Name of Insurance _____ Policy no.: _____ Group no.: _____

Patient's relationship to subscriber: Self Spouse Child Co-payment: _____

Name of Secondary insurance (if applicable): _____ Subscriber's name: _____ Social Security no.: _____ Date of Birth: _____

Patient's relationship to subscriber: Self Spouse Child

Person responsible for bill: _____

MEDICAL INFORMATION

List all MEDICATIONS you now take: _____

Radiation treatment for any condition? Y N (if yes please explain): _____

Do you have or have you had any of the following conditions:

Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N
Ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Valve	<input type="checkbox"/> Y <input type="checkbox"/> N	Convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Murmurs	<input type="checkbox"/> Y <input type="checkbox"/> N	Alcohol Use	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N	Tobacco Use	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Substance Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N	Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Condition	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Tendency	<input type="checkbox"/> Y <input type="checkbox"/> N	Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid condition	<input type="checkbox"/> Y <input type="checkbox"/> N	Other	

Are you allergic to any of the following:

Adrenaline	<input type="checkbox"/> Y <input type="checkbox"/> N	Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N	Polysporin	<input type="checkbox"/> Y <input type="checkbox"/> N	Atarax	<input type="checkbox"/> Y <input type="checkbox"/> N
Eurax	<input type="checkbox"/> Y <input type="checkbox"/> N	Kwell	<input type="checkbox"/> Y <input type="checkbox"/> N	Bacitracin	<input type="checkbox"/> Y <input type="checkbox"/> N	Griseofulvin	<input type="checkbox"/> Y <input type="checkbox"/> N
Retin-A	<input type="checkbox"/> Y <input type="checkbox"/> N	Bactrim	<input type="checkbox"/> Y <input type="checkbox"/> N	Keflex	<input type="checkbox"/> Y <input type="checkbox"/> N	Salicylic Acid	<input type="checkbox"/> Y <input type="checkbox"/> N
Benadryl	<input type="checkbox"/> Y <input type="checkbox"/> N	Micatin	<input type="checkbox"/> Y <input type="checkbox"/> N	Sulfa	<input type="checkbox"/> Y <input type="checkbox"/> N	Benzoyl Peroxide	<input type="checkbox"/> Y <input type="checkbox"/> N
Minocin	<input type="checkbox"/> Y <input type="checkbox"/> N	Tar Preparation	<input type="checkbox"/> Y <input type="checkbox"/> N	Carbocaine	<input type="checkbox"/> Y <input type="checkbox"/> N	Neosporin	<input type="checkbox"/> Y <input type="checkbox"/> N
Tetracycline	<input type="checkbox"/> Y <input type="checkbox"/> N	Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N	Novacaine	<input type="checkbox"/> Y <input type="checkbox"/> N	Xylocaine	<input type="checkbox"/> Y <input type="checkbox"/> N
Cortisone	<input type="checkbox"/> Y <input type="checkbox"/> N	Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N	Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N	Other	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize JOSHUA BERLIN, M.D., and/or MARK GARDNER, M.D., and/or J.JOHN GOODMAN, M.D., and/or HOWARD A GREEN, M.D., and/or J. DANIEL MARDEN, M.D., and/or ROBERT A. SARRO, M.D., and/or BRENT SCHILLINGER, M.D., and/or BRETT DOCK, M.D., or any other health care professional of Dermatology Associates, P.A. to release any information required to process my claims.

 Patient/Guardian signature Date