PATIENT REGISTRATION FORM

TODAY'S DATE: **PCP:**

PATIENT INFORMATION

Legal Name: (First, Middle, Last)			Preferred Name:	
Address:		City:	State:	Zip:
Phone Number:	Other Number:	Email:	Preferred method of communication: □ Phone □ TEXT □ Email	
Date of Birth:	Social Security Number:	Marital Status: □ Married □ Single □ Divorced □ Widowed	Sex: M F	Preferred language: □ English □ Spanish □ Other

EMPLOYMENT / SCHOOL INFORMATION

Employed: □ Full Time □ Part Time **Student:** □ Full Time □ Part Time	Employer/School:	Position:
Employer/School Address:		Work Phone:

EMERGENCY INFORMATION

Person to Contact in Case of Emergency:	Relationship to Patient:
Phone:	May we speak with this person to regarding your medical condition? YES or NO

RESPONSIBLE PARTY FOR MINORS

If Patient is a Minor, Responsible Party's Name PRESENT WITH CHILD:	Relationship to Patient:
Address:	Phone:

REFERRAL INFORMATION

How were you referred to our practice? □ Physician			Primary Care Physician:
□ Friend/Relative	□ Website	□ Social Media	□ Other:

751 Walnut Knoll Lane Suite 2, Cordova info@901SkinMD.com 901-707-7431

PATIENT REGISTRATION FORM

INSURANCE INFORMATION:			
Primary Insurance			
Primary Insurance Company Name::		Network:	
Policy Holder Name (if other than patient):	Policy Holders DOB:	Relationship to policy holder : ☐ Self ☐ Spouse ☐ Child ☐ Other	
Employer:	Policy Holder's SS #:	Individual ID Number:	Group Number:
Secondary Insurance			
Secondary Insurance Company Name::		Network:	
Policy Holder Name (if other than patient):	Policy Holders DOB:	Relationship to policy holder : ☐ Self ☐ Spouse ☐ Child ☐ Other	
Employer:	Policy Holder's SS #:	Individual ID Number:	Group Number:

PHARMACY INFORMATION	
Pharmacy Name:	Pharmacy Phone:
Pharmacy Address:	

_____ Initials **I have read this form and certify those information is true and correct to my knowledge.**

_____ Initials **I acknowledge that I have received a copy of the Privacy Practices.**

_____ _____

Signature of Patient Date

_____

Patient's Printed Name

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MEDICAL HISTORY FORM

PATIENT NAME: **DATE OF BIRTH:** **DATE:**

ALLERGIES & REACTIONS	
Are you allergic to any medications? : □ Yes □ No If Yes, please list	
Medication Allergies List:	Reaction:
1.	1.
2.	2.
3.	3.

CURRENT MEDICATION		
Please list of ALL current medications: including prescriptions, over the counter, vitamins and supplements, or eye drops		
Medicine Name:	Dose:	How Often:
1.	1.	1.
2.	2.	2.
3.	3.	3.

PERSONAL and FAMILY MEDICAL HISTORY

Please check if you or a family member (FM) have ever had any of the following:

	You	FM		You	FM		You	FM
Acne			Eczema			Melanoma		
Arthritis			Hay Fever			Non- Skin Cancer		
Asthma			Hives			Skin Cancer		
Diabetes			Lupus			Psoriasis		

PAST Surgeries & Dates:

SOCIAL HISTORY	
□ Smoker: Never _____ Current _____ Past _____ □ Smokeless Tobacco □ Drugs □ Alcohol: Current _____ Past _____ Don't Drink _____	1. Have you used a tanning bed? YES or NO 2. Have you ever been vaccinated for Hepatitis? YES or NO **Women** (Are you Pregnant?) YES or NO Due Date_____

_____ _____

Signature of Patient Date

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