



Patient Registration

Prefix _____ Name _____

Nickname (if any) _____ Personal Physician _____

How did you hear about our office?

- Referred by Physician. Which? _____
- Referred by Friend. Whom? _____
- Newspaper or Magazine. Which? _____
- Web Site. How did you find our site? _____
- Phone Book. Which? _____
- Other _____

Personal Information

Address _____

City, State, Zip _____

Social Security No _____ - _____ - _____ Birthdate ____/____/____

Home Phone _____ Work Phone _____

Cell Phone _____ (for office use only)

Email Address _____ (for office use only)

Are you? Married Single Divorced/Separated Widowed
 Gender Male Female

Spouse's Name (if Married) _____

Spouse's Employer _____ Home Phone _____

Work Phone _____ Cell Phone _____

Are you? Retired Student

Occupation _____ Company Name _____

In Case of Emergency, Please Contact _____
Relationship _____ *Phone Numbers* _____

Insurance Information (Please inform us if you have **secondary insurance** as well)

Name of Insured _____ Relationship _____

Employer _____

DOB of Insured ____/____/____ Social Security No _____ - _____ - _____

Insurance Company _____

Policy No _____ Group No _____



Patient Health History

To help us provide you with optimal health care, please take the time to accurately complete this form. Please note your answers are strictly confidential. Thank you very much.

Name _____ Occupation _____

Age _____ Height _____ Weight _____ Are you actively dieting? YES NO

Reason for your visit today? _____

List your Significant Medical Problems _____

List your Previous Operations (including Cosmetic Procedures).

Operation

Year

Are you Allergic to any Medications? What happened when you took these medications? (include reactions to tape, iodine, local anesthetics, etc.) _____

Are you currently on any Medications? (include over-the-counter meds & supplements)

Table with 3 columns: Medication, Dose, Frequency. Contains 5 empty rows for data entry.

Do you take Aspirin, Motrin, or any Blood thinners on a regular basis? YES NO If YES, what for? _____

Have you been on steroids (Cortisone/Prednisone) in the last year? YES NO If YES, what for? _____

Are you a smoker? YES NO How much do you smoke or when did you Quit? _____

How much do you drink? Never Occasionally Nightly (1-2 drinks) Frequently

Have you ever used recreational drugs? YES NO If YES, which? _____

(For Women Only) Are you pregnant? YES NO Are you breastfeeding? YES NO

Are you under the care of a Psychiatrist or Psychologist? YES NO If YES, what for? _____

Are there any Cancers that run in your family? YES NO If YES, please explain. _____

Is there a History of Heart Problems, Strokes, or Blood Clots in the Family? YES NO If YES, please explain. _____

Are there any other serious Medical Conditions that run in the Family? YES NO



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If YES, please explain. _____

Have you ever had Skin Cancer? YES NO

If YES, please explain. _____

Do you have a history of any of the following conditions?

Condition	YES	NO	If YES, please explain
Heart Murmur/Damaged Heart Valves?			
Do you take Antibiotics prior to dental work?			
High Blood Pressure?			
Low Blood Pressure?			
Chest Pain/Angina?			
Heart Attack or Stroke?			
Irregular Heart Beat or Pacemaker?			
Asthma or Lung Disease?			
Tuberculosis?			
Shortness of Breath with Walking?			
Pain in the calves with Walking?			
Anemia or Blood Disorders?			
Bleeding Problems (Do you bruise easily)?			
Clotting Problems (DVT,Pulmonary Embolus)?			
Hepatitis or HIV?			
Liver or Kidney Disease?			
Seizures or Epilepsy?			
Thyroid Problems?			
Diabetes?			
Stomach Ulcers?			
Fever blisters of the lips or Herpes?			
Immune system or healing problems?			
Mental Health Problems?			
Glaucoma or Eye disease?			
Dry eyes?			
Do you wear Contact Lenses?			
Radiation Therapy or Chemotherapy?			
Blood transfusion?			
Family history of Malignant Hyperthermia?			
Do you form large scars or keloids?			

Is there any other information that you would like to share that may be helpful in your care?

The above information is true to the best of my knowledge. I will not hold my surgeon or his office responsible for any errors or omissions that I may have made in completion of this form.

Signature _____ Date _____

(FOR OFFICE USE ONLY) The above patient health history including past medical/surgical history, medications, allergies, family and social history and review of systems has been reviewed with the patient.

_____ E. Chang MD