PATIENT HISTORY AND REGISTRATION
THE CENTER FOR COSMETIC AND LASER SURGERY

PERSONAL INFORMATION

Patient Name: _____

Email Address: _____

Phone: (Home) _____/(Work)_____

(Cell) _____

Best Daytime Contact Number:_____

Address: _____

City/State/Zip: _____

Birthdate: _____/M_____F_____

SS# _____

Marital Status: S_____M_____D_____W_____

Employer: _____

Spouse/Nearest Relative: _____

Relationship: _____/Phone: _____

Emergency Contact: _____

Relationship: _____/Phone: _____

Primary Physician: _____

Referring Physician: _____

RESPONSIBLE PARTY/ INSURANCE INFORMATION

Responsible Person Name: _____

Address: _____

Phone: (Home) _____/(Work)_____(Cell)_____

Address: _____

City/State/Zip: _____

Birthdate: _____/M_____F_____

SS# _____

Marital Status: S_____M_____D_____W_____

Employer: _____

Primary Insurance: _____

Relationship to Insured: Self____Souse____Child____

Secondary Insurance: _____

Relationship to Insured: Self____Souse____Child____

Is This a Work Comp Case? Yes_____No _____

Is This Related To An Auto Accident?
Yes_____No _____
If Yes, Date: _____

Information Reviewed/Updated

Reason for visit: _____

Date Symptom Began: _____

PERSONAL MEDICAL HISTORY

__High Blood Pressure
__Heart Attack
__Chest Pain
__Stroke
__Cancer
__Diabetes
__Epilepsy
__Bleeding Disorder
__Kidney Disease
__Thyroid Disease
__Mental Illness
__Asthma
__Hepatitis
__Arthritis

Other/Explanation of Above:

_____
_____
_____
_____
_____

Previous Surgeries & Hospitalizations **Date**

_____
_____
_____
_____
_____

Height: _____ Weight: _____

Smoke: _____Packs/Day – How Long? _____

Alcohol: _____Type/Amount: _____

Date of Last Tetnus: _____

Date of Last Mammogram: _____

Monthly Self-Breast Exam? Yes _____No_____
Pregnant? Currently___Yes___No/ Anticipating being ___Yes___No
HIV Testing: _____Date / Results: _____

Current Prescription Medications:

_____
_____
_____
_____

Current Non-Prescription Medications/Vitamins/Herbs/Aspirin:

_____
_____
_____
_____

Allergies:

_____
_____
_____
_____