

PATIENT REGISTRATION

Name (Last, First, MI): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home _____ Business _____

Telephone: Mobile _____ Email Address: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: S M D W

Social Security #: _____ Drivers License #: _____

Referred By: _____ Family Physician: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Number: _____ Co-Payment: _____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____ Social Security # _____

Name and Address of Employer: _____

Name and Address of Employer: _____

Emergency Contact Name: _____

Telephone: _____ Relationship: _____

I hereby authorize my insurance benefits to be paid to John W. Decorato, M.D. realizing I am responsible for all non-covered services and hereby authorize release of pertinent information to insurance carriers.

Patient / Responsible Party Signature

PATIENT INFORMATION AND MEDICAL HISTORY

The information contained in this form will remain confidential and will not be released to any party without the patient's express written consent. Please answer all questions to the best of your knowledge.

Last Name: _____ First Name: _____ MI: _____
Age: _____ Height: _____ Weight: _____
Family Physician: _____ Referring Physician: _____

Reason for Consultation: _____

MEDICAL HISTORY

Do you have or have you had? (Circle any that apply)

AIDS or HIV	Diabetes	Asthma
Arthritis	Heart Attack	Lung Disease
Hepatitis	High Blood Pressure	Stroke
Blood Transfusion	Mitral Valve Prolapse	Epilepsy
Back Problems	Arrhythmia	Ulcer Disease
Breast Disease	Heart Surgery	Digestive Problems
Cancer	Kidney Disease	Skin Cancer
Cold Sores	Thyroid Disease	Skin Infections

Please describe any other serious illness: _____

Do you smoke? Yes No If yes, how much? _____
Did you ever smoke? Yes No If yes, when did you quit? _____
Do you drink alcohol? Yes No If yes, how much? _____

Are you presently taking any medications or vitamins? Yes No (Please list with dosage)

Please list any surgery you have had? _____

Have you ever had any problems with anesthesia? _____

Are you allergic to any medications? If yes, please list _____

Do family members have any medical problems? (Please list family member and problem) _____
