PATIENT REGISTRATION

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.

Name: (Last, First, MI): ____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Social Security #: ____________________

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

Telephone: Home: ____________________ Business: ____________________

Telephone: Mobile: ____________________ Email: ____________________

Preferred Contact: Home Business Mobile

Emergency Contact Name: ____________________

Telephone: ____________________ Relationship: ____________________

Referred By: ____________________ Family Physician: ____________________

How did you hear about Dr. Decorato? ____________________

INSURANCE IF APPLICABLE

Insurance Company Name: ____________________

Insurance Policy ID number: ____________________

Name of Policy Holder: ____________________

Policy Holder Date of Birth: ____________________ Social Security # ______________

Secondary Insurance Carrier: ____________________ Policy Number: ______________

____

Patient/ Responsible Party Signature Date

PATIENT INFORMATION AND MEDICAL HISTORY

Last Name: ____________________ First Name: ________________ MI: ________

Age: ________ Height: _______ Weight: _________

Reason for Consultation: ____

MEDICAL HISTORY

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

AIDS or HIV	Diabetes	Lung Disease
Arthritis	Digestive Problems	Mitral Valve Prolapse
Asthma	DVT/PE	Skin Cancer
Back Problems	Eczema	Skin Infections
Bleeding Disorder	Hepatitis	Stroke
Blood Transfusion	Heart Attack	Thyroid Disease
Breast Disease	Heart Disease	Tuberculosis
Cancer	High Blood Pressure	Ulcer Disease
Cold Sores	Kidney Disease	Vascular Disease
Cholesterol		Weight Loss (excessive)

Please describe any other serious illness:

____

Please list any surgery you have had?

____

Have you ever had any problems with anesthesia?

____

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

____

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

____

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

____

____

Do you drink alcohol? Yes No If yes, how much? ____________________

Do you smoke? Yes No If yes, how much? ____________________

Did you ever smoke? Yes No If yes, when did you quit? ________________

PHARMACY Name/Address/Phone# ______________________________________

____

FEMALES (please circle)

Do you have regular periods? YES NO N/A

Are you going through menopause? YES NO N/A

Are you pregnant or lactating? YES NO N/A

Have you ever been pregnant? YES NO # of children________

During pregnancy did you ever get Hyperpigmentation or masking? YES NO N/A

Did you breast feed? YES NO N/A

PRIVACY NOTICE TO PATIENTS

Thank you; if you have any questions, please direct them to Gloria Castellucci, M.A.

Please sign below acknowledging receipt of Dr. Decorato's Privacy Notice. Your signature only states that you have received this notice. This document will be maintained in your medical record.

Patient Signature	Print Name	Date