Patient Registration Form

Please bring insurance card and photo ID to your appointment

Patient Name _____ Date of Birth _____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell #_____Work # _____

Circle your contact preference: Home phone Cell phone Work phone Email
Email _____ I do not have email _____
May we send you an email appointment reminder? Yes _____ No _____

How were you referred to our practice?

- ☐ **PCP? Please indicate your PCP's name: _____**
- ☐ **Other MD? Please indicate name and reason: _____**
  _____
- ☐ **Friend? _____**
- ☐ **Web site? _____**
- ☐ **Advertisement?_____**

Please give us the following information to facilitate our communication with your Primary Care:
Primary Care Name (first/last) _____ City _____
Did your doctor give you an insurance referral for our office Yes _____ No _____

Primary Insurance _____ Policy # _____ Group _____

Secondary Insurance _____ Policy # _____ Group _____

Policy Holder Name _____Policy Holder DOB _____ Relationship_____

Race: White_____ African American_____ American Indian _____ Asian_____

Hispanic /Latino _____ Non Hispanic/Latino _____ refused to answer_____

Pharmacy Name _____ Address _____

Phone # _____ Fax # _____

I have been able to review the Krauss Dermatology Notice of Privacy Practices (available in our office or on our website). This notice provides information about how Krauss Dermatology may use and disclose my protected health information, what its legal duties are regarding my protected health information, and what my rights are regarding my protected health information, and how I can file a complaint about these privacy practices. I understand that if I have additional concerns, I may ask the HIPAA compliance officer at Krauss Dermatology for clarification.

Yes _____ No _____ Signature _____ Date _____

Patient Name_____ Today's Date_____

Please read and darken the circles for the appropriate response regarding your medical history.

Female Patients Only

Currently Pregnant	O Yes	O No
Currently Breastfeeding	O Yes	O No

General

Allergies to Medication	O Yes	O No
Problems with anesthesia	O Yes	O No
History of Cancer	O Yes	O No

Constitutional

Recent fever or chills	O Yes	O No

Eyes

Vision Problems	O Yes	O No
Eye Pain/Discomfort	O Yes	O No

Neurological

Frequent or Severe Headaches	O Yes	O No
Numb/Tingling Hands or Feet	O Yes	O No

Endocrine

Diabetes	O Yes	O No
Always Tired/Sluggish	O Yes	O No

Gastrointestinal: Recent or Frequent

Abdominal Pain	O Yes	O No
Nausea/Vomiting	O Yes	O No
Indigestion/Heartburn	O Yes	O No

Cardiovascular

Pacemaker	O Yes	O No
Chest Pain	O Yes	O No
Varicose Veins	O Yes	O No
High Blood Pressure	O Yes	O No
Heart Valve Problem	O Yes	O No

Musculoskeletal

Joint Replacement	O Yes	O No
Joint Pain/ Arthritis	O Yes	O No

Ear/Nose/Throat: Recent or frequent

Ear Infection	O Yes	O No
Sinus Problems	O Yes	O No

Respiratory/ Allergic

Wheezing/ Asthma	O Yes	O No
Frequent Cough	O Yes	O No
Hay Fever	O Yes	O No

Hematologic/ Lymphatic

Bleeding Problems	O Yes	O No
Blood Clot or Stroke	O Yes	O No

Psychologic

Anxiety Disorder	O Yes	O No
Mood Swings	O Yes	O No
Depression	O Yes	O No

Have you or a family member ever had the following?

Melanoma	O Yes	O Family
Other Skin Cancer	O Yes	O Family
Psoriasis	O Yes	O Family
Eczema/Dermatitis	O Yes	O Family
Moderate or severe Acne	O Yes	O Family

Darken the circle if the answer is yes:

O Smoke

O Drink alcohol more than 4 drinks per week?

O Currently work? Occupation_____

O Live Alone?

O Wear sunscreen Regularly?

O Tan Regularly (tanning booth or outdoors)?

Why we ask: In dermatology, many conditions may be related to work exposures such as chemicals or intense sun. Also, recuperation from some medical or cosmetic procedures may interfere with work related tasks or public appearances. In addition, patients who live alone may need to have skin exams more frequently if we are following lesions on the back, or may need assistance with dressing changes after a procedure.

Patient Name_____

Please list any prescription medication you are regularly taking:

_____ _____

_____ _____

_____ _____

Please list any nonprescription medication you are regularly taking:

_____ _____

_____ _____

Please list any medication allergies (with type, such as hives, stomach upset) environmental or skin allergies:

_____ _____

_____ _____

Please describe any medical problems you checked "yes" to on the prior medical history sheet, or any other medical issues you have that were not listed:

_____ _____

_____ _____

_____ _____

_____ _____

Please list prior surgeries with approximate date of procedure:

_____ Date_____

_____ Date_____

_____ Date_____

We appreciate your time and effort in completing these forms. The information will help us treat you safely and effectively