DERMATOLOGY,
LASER & SURGERY
of CARNEGIE HILL PLLC

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last name: **First:** **Middle:**	❑ Mr. ❑ Mrs.	❑ Ms. ❑ Dr.	**Marital Status (Circle One):** Single / Mar / Div / Sep / Wid	
Birthdate: / /	**Age:**	**Sex: ❑M ❑ F**	**Social Security #:**	
Language: ❑English ❑ Spanish ❑French ❑ Chinese ❑Italian ❑ Other	**Ethnicity: ❑ Asian ❑ Caucasian ❑ Hispanic ❑African American ❑ Other**		**Religion:**	
Street Address:	**City:**	**State:**	**Zip Code:**	
Home Phone :	**Cell :**	**Work :**	**Fax:**	
Email:				
Primary Care Physician (First /Last):	**Primary Care Physician #:**	**Pharmacy Name:**	**Pharmacy #:**	
Occupation:	**Emergency Contact Name:**		**Emergency Contact #:**	
Referred By: ❑ Friend/Family	**❑ Dr.**	**❑ Online**	**❑ Insurance Plan**	

MEDICAL HISTORY

Reason For Today's Visit:

Drug Allergies:

Current Medications:

Skin History:

❑ Acne	❑ Basal Cell Cancer	❑ Dysplastic Nevi	❑ Eczema	❑ Keloids
❑ Melanoma	❑ Psoriasis	❑ Squamous Cell Cancer	❑ Warts	❑ Other: _____

Medical History: **Height :_____** **Weight:_____**

❑ Diabetes	❑ Heart Murmur	❑ Heart Valve	❑ Hepatitis B	❑ Hepatitis C
❑ High Blood Pressure	❑ High Cholesterol	❑ HIV	❑ Pregnant/Nursing	❑ Other: _____

Surgical History:

Family History:

❑ Basal Cell Cancer	❑ Eczema	❑ Melanoma	❑ Psoriasis	❑ Squamous Cell Cancer

Social History: **Smoker: ❑ Yes ❑ No**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance and co-payments are due at the time of service. I also authorize Dermatology, Laser and Surgery of Carnegie Hill PLLC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**