PLEASE FILL OUT THIS FORM IN ITS ENTIRETY

Academic Dermatology - Patient Registration Form

75 Veronica Ave, Suite 205, Somerset, NJ 08873
Phone: (732) 246-9900; Fax: (732) 246-9902

Patient Name____ Prefer to be called____________________
First Middle Last

Address______________________________City_______________State_____Zip______________

Home Phone(____)_____________ Work Phone(____)_______________ **Other/Cell**(____)__________________

Date of Birth_____________**Age**_______**Sex**___Soc. Sec. #____________________Today's date___________

Employer____
Name Address Phone

Primary Insurance____
Name ID# Group# Phone Name of Insured (if different)

Secondary Insurance____
Name ID# Group# Phone Name of Insured (if different)

Relationship of Patient to Insured (if different)__________________ ***Referred by***____________________________

Responsible party/Primary cardholder (if different)____
First Middle Last Relationship to Patient

____
Address City State Zip Home phone Work phone

Date of Birth_____________Age_______Sex___Soc. Sec. #____________________

In case of emergency, who should be notified____

Allergies to: *Medications*______________________________________ *Foods/other*_______________________

Past Surgeries____________________________________**Reactions to dental anesthesia**_____________________

Current Medications (incl. non-prescription) ____
____

Primary pharmacy: ____________________ Phone & Address ____

Do you take daily Aspirin?_______**Ibuprofen**?_________**Other blood thinners**?_____________________________

Please circle any of the following conditions that you have or have had and elaborate below:

Heart Murmur	Artificial Heart Valve	Artificial Joint	Metal Prosthetic
Pacemaker	Other heart disease	Bleeding disorder	High blood pressure
Liver disorder	Kidney disorder	Thyroid disorder	Cancer
Asthma/Hay fever/	Diabetes	Stomach/gastrointestinal	Neurologic
Seasonal allergies	HIV/AIDS	Immune disorders	Other: _____________

Have you had skin cancer________________________**Other specific skin diseases**_______________________
Problems with healing__________ **Do you develop keloids (excessive scars) after surgery**_____ **Bleed easily**_______
Are you required to take antibiotics before you have a dental cleaning?__________
Any Family History of any medical (*skin*) problems/conditions____
Do you drink alcohol?______________**smoke**?_____________ **(WOMEN) Are you pregnant**?________________

I authorize the release of medical information to my referring physician, to consultants if needed, and as necessary to process insurance claims. I authorize payment of medical benefits to the physician. I understand that I am responsible for any amount not covered by insurance.
Patient or Responsible Party Signature X______________________________________ Date________________

I have reviewed the HIPAA Notice of Privacy Practices.
Patient or Responsible Party Signature X______________________________________ Date________________

Do we have your permission to leave a message on an answering machine______, to call you at work________,
to discuss with any household members (state whom)____